



**REPORT**  
**OF THE**  
**HEALTH SURVEY AND DEVELOPMENT**  
**COMMITTEE**



**Vol. I**

**SURVEY**

**PUBLISHED BY THE MANAGER OF PUBLICATIONS, DELHI**  
**PRINTED BY THE MANAGER, GOVERNMENT OF INDIA PRESS, CALCUTTA**  
**1946**

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# REPORT OF THE HEALTH SURVEY & DEVELOPMENT COMMITTEE

## VOLUME I

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### A SURVEY OF THE STATE OF THE PUBLIC HEALTH AND OF THE EXISTING HEALTH ORGANISATION

#### INTRODUCTION

The Health Survey and Development Committee was appointed by the Government of India in October 1943 to make (a) a broad survey of the present position in regard to health conditions and health organisation in British India, and (b) recommendations for future developments. The letter dated 25th October 1943 from the Government of India to the Chairman of the Committee in regard to its appointment and work is reproduced below and the press *communiqué* referred in the letter is given as Appendix 56 in Volume III of this report.

“ I am directed to forward a copy of the press *communiqué* announcing the appointment of the Health Survey and Development Committee. The terms of reference of the Committee will, as stated in the *communiqué*, be to make a broad survey of the present position in regard to health conditions and health organisation in British India and to make recommendations for future development. The terms of reference have been framed in general terms in order to leave the fullest possible freedom to the Committee in its treatment of the subject matter of the inquiry.

2. A survey of the whole field of public health and medical relief has not hitherto been attempted. The immediate necessity for initiating such a survey has arisen from the fact that the time has come to make plans for postwar development in the health field. The Government of India consider that such plans should be based on a comprehensive review of the health problem.

3. It will be observed that the terms of reference mention firstly a survey of existing conditions and organisation and secondly suggestions for future development. The Government of India regard the first item as of no less importance than the second. A survey which will give a general picture of the present position and which will indicate, and place in

proper perspective, the causes of a low level of health and the problems to be solved must be of the greatest value to all who are concerned with problems of health. A review which extended to all factors which have a direct or indirect bearing on the health of the community would cover a very large range of Government and private activity. The Committee has been constituted to review primarily those activities which can reasonably be regarded as falling within the scope of health administration. Turning to the question of future development it is unlikely that any committee would be able to produce within a limited period a solution for each of the many varied problems in the health field and it is recognised that in some cases the Committee may be able to do no more, within the limitations under which they have to perform their task, than to suggest various possible directions in which a solution may be sought or to indicate the need for further special inquiry. The Committee may wish to consider the question of indicating, where possible, both short-term objectives—objectives which might reasonably be expected to be reached within a period of four to five years—and objectives which will necessarily require a longer period for attainment.

4. One of the difficulties with which the Committee will be confronted is that of finance. Financial considerations clearly cannot be ignored. Plans based on the assumption that unlimited funds will be available for recurring expenditure will have little practical value. On the other hand it would be equally unwise to assume that expenditure on health administration will in the future be limited to the sums which were expended in the pre-war years. It is desirable, therefore, to plan boldly, avoiding on the one hand extravagant programmes which are obviously incapable of fulfilment and on the other halting and inadequate schemes which could have no effect on general health standards and which would bring little return for the expenditure involved.

5. The Committee will have power to appoint sub-committees for the consideration of particular subjects and to appoint to such sub-committees persons who are not members of the Committee but whose special knowledge of the subject matter of the inquiries will be of value.

6. War conditions must necessarily impose limitations on the Committee's activities and procedure. The difficulties of obtaining accommodation in the large towns and the necessity for restricting railway travel will make it impracticable for the Committee as a body to tour. It will be possible for small groups or sub-committees to visit particular places for a specific purpose but it is hoped that in view of the prevailing conditions the number of members of such groups or sub-committees will be restricted to the minimum. Reference should also be made to the collection of statistical and other material. Most provincial administrations have already a very

heavy burden to bear owing to the abnormal conditions and it will be difficult for them to collect voluminous statistics and other material specially for the Committee. Provincial Governments, however, have a large amount of material readily available in published reports or elsewhere and it is hoped that the Committee will find that such material will in most cases be adequate for the Committee's purpose. It will of course be possible for the Committee to supplement the information available in such reports by examining selected witnesses.

7. Reference has been made above to the preparation of plans by Governments for post-war development. It is clear that, if the cessation of hostilities is not to find Governments unprepared, the completion of such plans cannot be long delayed and it is, therefore, important that the results of the Committee's inquiry should be available as soon as possible.

8. The Government of India are aware that the task which they have entrusted to the Committee is one of great difficulty. The great range and variety of problems which go to make the single problem of preventing and curing disease and raising the general standard of health of the community, the varying conditions and stages of development in different Provinces, and the special needs of urban and rural areas and of the industrial and agricultural populations, are all factors which make the subject to be investigated a matter of great complexity. In addition the difficulties must inevitably be enhanced by the present abnormal conditions. The Government of India are satisfied, however, that the time has come when the inquiry must be undertaken and I am to express their gratitude to you and the members of the Committee who, in spite of other heavy claims on their time, have agreed to serve on this Committee."

2. We addressed ourselves to the task before us by dividing the wide field to be covered between 5 Advisory Committees dealing with the subjects of (i) public health, (ii) medical relief, (iii) professional education, (iv) medical research and (v) industrial health.

These Advisory Committees, which were composed of members of the Health Survey and Development Committee and of *ad hoc* co-opted members specially qualified to assist them in their task, were entrusted with the work of conducting detailed investigations into the subjects allotted to them, close liaison between them being ensured by inter-committee meetings and by periodic joint discussions. The composition of these Advisory Committees is shown in Appendix 57. It was felt necessary for the Health Committee to establish contact through tours in the Provinces with actual health conditions in the country and put to the test of such personal investigation as might be possible the character of the health services available to the public. For this purpose, the Committee was divided into 4 groups whose tours covered every Province in India except Assam and Baluchistan. Owing to the

limitations imposed by existing difficulties in connection with travelling and accommodation and by the over-riding time factor, touring had inevitably to be of a very restricted nature both in regard to the ground covered and the time expended. The necessity for the presentation of our report as early as possible had been repeatedly emphasized and any detailed examination of medical institutions, health conditions and the various health services open to the public, which would have postulated close and extended investigations, was therefore impracticable.

It may be remarked that the Goodenough Committee in the United Kingdom, with very much more restricted terms of reference covering as they did only the subjects of medical education and research and dealing with a country much smaller and more homogeneous than India, took about 26 months to complete its task. We have taken the same period of time to produce our Report which covers a much wider field and deals with more complex and difficult conditions. The visits paid to the Provinces had, for the reasons stated, perforce to be shorter and more cursory than we should have liked them to be. Nevertheless even these visits served a most useful purpose in disclosing defects and lacunae in the medical services available to the country, in showing some of the more important weaknesses in the existing medical and public health organisation and in establishing contact with interested public opinion, professional and otherwise, at various centres in the country.

3. A list of subjects under our consideration was prepared in some detail and copies of it were circulated to the Provincial Governments with a request for comments and suggestions in regard to any in the wide range of subjects included in the list. Individuals and organisations were invited to give written and oral evidence before the Committee's touring groups in respect of any particular problems in which they might be specially interested. Detailed questionnaires were drawn up by the Advisory Committees and were sent to the Heads of Medical Departments in the Provinces, to the Principals of Medical Colleges, Superintendents of Hospitals, Public Health Authorities, all Medical Associations in the country and to a number of individual medical men and social workers in the Provinces. As a result of these requests for evidence, criticism and suggestions, over 200 memoranda were received and about 450 witnesses offered themselves for examination by the Touring Groups; the Advisory Committees and the main Health Committee itself. Information in regard to the written memoranda considered by us is given in Appendix 58 of Volume III. Wherever it was possible to draw upon the experience of professional men and social workers outside our own ranks, the various Advisory Committees took full advantage of this source of assistance. Expert Committees composed of such individuals with special knowledge or experience of the subjects concerned were constituted to advise them in regard to basic medical education, dental education, pharmaceutical education, tuberculosis, mental hygiene and medical research. A special conference of

representatives of the nursing profession in India was held under our auspices to survey existing conditions and make recommendations for the future. We also had the privilege of discussions with Mr. Yeatts in regard to vital statistics and the population problem and with Professor B. P. Adarkar on the subject of medical benefits for workers. We desire to express our deep sense of obligation to all those who gave so freely of their time, and at considerable sacrifice of personal convenience, travelled long distances to place their great technical knowledge and experience at our disposal in connection with our work.

At an early stage of our deliberations, we recognised that a study of the health work and services in foreign countries would be of the utmost value in formulating our own proposals. This, however, was found to be impracticable. Not only did the limitations imposed by the time factor render this so but the difficulty of transport for what would have had to be a considerably large and representative delegation of the Committee, put visits abroad out of the question under existing conditions. The next best course had, therefore, to be adopted and 6 distinguished workers in the medical world from the United Kingdom, the United States and Australia were invited to come to India to assist us in our task. They were followed later by a representative of the Soviet Government and the Committee had the benefit, at an early stage of its sittings, of meeting Professor A. V. Hill, F.R.S., and discussing with him problems pertaining to medical education and medical research. The main object of inviting these visitors from abroad was not to seek advice in regard to our own peculiar problems but to obtain from workers of the highest standing in their respective countries with practical experience of many common problems, information as to how these were being dealt with elsewhere, what difficulties had been experienced and what the trends of thought were in countries most advanced in providing medical and public health services for their people. Further, by showing them conditions as they exist in India, we hoped to ascertain how far these conditions were comparable with those prevailing in their respective countries so that we might be able to draw, with greater confidence, our own conclusions as to how far measures adopted elsewhere were likely to be fruitful in the case of India.

In regard to Russia, we were particularly anxious to know something about the conditions which prevailed before the drive began to improve medical and health facilities for the Russian people, how far those conditions approximated to conditions prevailing at the moment in India and by what measures the great success that has been attained under the Soviet régime in this regard was achieved.

We wish to record our debt of gratitude for the most valuable assistance we have derived from our contact with these visitors and the detailed information which they made available to us through an examination conducted by us over many days.



## INTRODUCTION

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Nor must we forget to mention the most valuable help we received from Lt.-Col. C. A. Bozman, I.M.S., the Acting Public Health Commissioner and Lt.-Col. D. P. McDonald, I.M.S., without whose ungrudging assistance we should not have been able to complete our task in the time that we have.

A part-time committee such as ours is peculiarly dependant on its Secretariat and we feel we must make specific mention of the willing and efficient help we received from ours. To Dr. K. C. K. E. Raja, our Secretary, we owe a very special debt. His knowledge, experience and capacity for work proved to be a never-failing reservoir from which we drew heavily at every turn. We desire to make specific acknowledgment of the invaluable assistance he has given to us. We should also like to express our warm appreciation of the work of our Assistant Secretary, Mr. Dwarka Dass, who kept the machinery of our Secretariat working at a remarkably high level of efficiency under most difficult and trying conditions.

Finally, to our Joint Secretaries, who never spared themselves, we are also greatly indebted for their devoted labours.



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## CHAPTER I

### A BRIEF SURVEY OF THE STATE OF THE PUBLIC HEALTH

1. In this volume of our report we shall attempt to draw a picture of the state of the public health in the country and of the existing health organisation. While the succeeding chapters will deal with various aspects of health administration in some detail, we shall endeavour here to give a bird's eye view of the situation. In attempting to do so it seems essential to exclude the abnormal conditions which arose out of the world war. The entry of Japan into the war in December 1941 marked the stage at which war conditions began to have serious adverse effect on India. The statistical and other information, which have been included for the purpose of throwing light on the state of the public health, have generally been limited to the year 1941 and the preceding period of ten years.

2. The term health implies more than an absence of sickness in the individual and indicates a state of harmonious functioning of the body and mind in relation to his physical and social environment, so as to enable him to enjoy life to the fullest possible extent and to reach his maximum level of productive capacity. In every community there are three classes of persons, namely, those whose level of health is so low that they are victims of disease, others who, while they manifest no definite signs of sickness, are yet so devitalised that the possible range of their physical and mental achievements is considerably restricted and a third class consisting of those who are blessed with an abundance of life and vigour. An assessment of the state of the public health in a country should, therefore, be based on information relating to all these three classes of people. But data regarding positive health are more difficult to collect than those relating to sickness and mortality and, in all countries, statistical and other information regarding the former is available on a much more limited scale than information in respect of the latter. This is particularly so in India, and in the brief review of health conditions presented in the succeeding paragraphs, attention will be confined mainly to statistics of ill-health and death.

TABLE I.—*A comparison of Indian mortality rates and expectation of life with those of certain other countries*

Serial No.	Country	Death rate (1937)	Infantile mortality rate (1937)	Expectation of life at birth	
				Males	Females
1	New Zealand . . . .	9.1	31	65.04	67.88 (1931).
2	Australia . . . . .	9.4	38	63.48	67.14 (1932-34).
3	Union of South Africa .	10.1	37	57.78	61.48 (1925-27). (European population).
4	Canada . . . . .	10.2	76	59.32	61.59 (1929-31).

TABLE I.—*A comparison of Indian mortality rates and expectation of life with those of certain other countries—contd.*

Serial No.	Country	Death rate (1937)	Infantile mortality rate (1937)	Expectation of life at birth	
				Males	Females
5	United States of America	11.2	54	59.12 47.55	62.67. (White population). 49.51. (Negro population). (1929-31). (1932-34).
6	Germany . . . .	11.7	64	59.86	62.75 (1932-34).
7	England and Wales .	12.4	58	58.74	62.88 (1930-32).
8	Italy . . . . .	14.2	109	53.76	56.00 (1930-32).
9	France . . . . .	15.0	65	54.30	59.02 (1928-33).
10	Japan . . . . .	17.0	106	44.82	46.54 (1926-30).
11	Java . . . . .	18.8			
12	Palestine . . . .	18.9	153		
13	Federated Malay States	19.9	147		
14	Ceylon . . . . .	21.7	158		
15	British India . . .	22.4	162	26.91	26.56 (1921-30).
16	St. Settlements . .	22.5	156		
17	Egypt . . . . .	27.2	165		

3. It will be seen that India's death rates for the community, as a whole, and for infants (children under one year of age) rank high in comparison with the corresponding rates of most of the countries mentioned above. The rates relate to 1937 because they are the latest available from the annual epidemiological reports of the League of Nations. Similar rates for British India in 1941 were 21.8 per 1,000 population and 158 per 1,000 live births; they do not affect the position of India in the tabular statement. The level of health in the country, as judged by these rates, is therefore low. The figures for expectation of life tell the same tale because they express, in terms of the probable length of life of the individual, the cumulative effect of the specific mortality rates at different ages in respect of the two sexes: the higher the specific death rates in a community the smaller will be the expectation of life.

4. The specially vulnerable groups in any community are children, particularly those in the first year of life, and old people. In addition, women at the reproductive ages are exposed to special risks during pregnancy and child-bearing, and maternal morbidity and mortality are factors which require special consideration in estimating the state of the public health.

The rates of mortality among infants and children and among mothers are examined below in greater detail.

### **Deaths among Infants and Children**

5. Deaths among infants and among children under 10 years of age in British India and in England and Wales are shown below as percentages of the total deaths at all ages in the two countries.

*Deaths at specific age-periods shown as percentages of the total deaths at all ages*

	Under one year	1-5 years	5-10 years	Total under 10 years
British India (average for 1935-39)	24.3	18.6	5.5	48.4
England & Wales (1938)	6.8	2.1	1.1	10.0

It will be seen that, in India, nearly half the total deaths are among children under 10 years of age and that, of the mortality in this age group, one half takes place within the first year of life. The percentage for England and Wales in every age group shown above is very much smaller.

### **Maternal Mortality**

6. The recorded rates for maternal mortality in the provinces vary considerably, ranging from such low figures as 0.06 per 1,000 births to about 12 per 1,000. These figures give an incorrect picture of the actual situation as revealed by special enquiries conducted in limited areas in different parts of the country. Taking into consideration the results of these enquiries, a special Committee appointed by the Central Advisory Board of Health to report on maternity and child welfare work in India came to the conclusion in 1938 that the rate for the country as a whole "is probably somewhere near 20 per 1,000 live births."

7. It has been estimated that, in British India, maternal deaths total annually about 200,000. With such a large mortality, the number of women suffering from varying degrees of disability and discomfort as a result of child-bearing must be very much larger, probably about four millions if estimates, made elsewhere, of the proportion of cases of mortality due to maternal causes to those of morbidity from the same causes can be taken as an approximate guide for India. It is clear that any plan for improving the health of the community must pay special attention to the development of measures for adequate health protection to mothers and children.

**The Prevalence of Diseases**

8. The average annual numbers of deaths in British India during 1932-41, from the epidemic diseases of cholera, smallpox and plague and from certain groups of causes, under which the remaining deaths are compiled, are shown below. The figures in brackets give the deaths under each head as percentages of the total number of deaths.

*Average Annual Deaths in British India, during 1932-1941,  
excluding Burma*

Cholera	Smallpox	Plague	Fevers	Dysentery and diarrhoea	Respira- tory diseases	Other causes	Total.
144,924 (2.4)	69,474 (1.1)	30,932 (0.5)	3,622,869 (58.4)	261,924 (4.2)	471,802 (7.6)	1,599,490 (25.8)	6,201,434 (100.0)

A striking feature of this table is that a number of diseases are grouped under such headings as 'fevers', 'respiratory diseases' and 'other causes'. The reason for this is that the organisation for reporting births, deaths and cases of infectious diseases is of a primitive type, particularly in the rural areas, where the greater part of the population lives. In these areas the village watchman is the reporting agent and the degree of accuracy regarding the cause of death is so low that only classification into such large groups such as 'fevers' and 'respiratory diseases' seems to be justified. The largest single cause of death under 'fevers' is undoubtedly malaria and, under 'respiratory diseases', tuberculosis. In the sections dealing with these diseases we have attempted to give as much information as is possible regarding their incidence but, in the absence of a well-developed health organisation over the country as a whole, and of a satisfactory agency for the registration of vital statistics, any estimates that are made in respect of these and other diseases must necessarily be conjectural. As regards cholera, smallpox and plague the people are familiar with their symptoms and, although no completeness of registration can be claimed, the recorded figures give a clearer indication of their incidence than in respect of most other diseases. These three (cholera, smallpox and plague) together contributed only 4.0 per cent. of the total mortality during the period 1932-41. Thus, compared with malaria and tuberculosis, the total extent of suffering, incapacitation and death caused by them appears to be definitely smaller. Nevertheless, it must be remembered that a disease like smallpox is perhaps more easily prevented than most other infectious diseases and should have been prevented long ago. India continues to be the largest reservoir of smallpox infection, although vaccination against it was the first preventive measure introduced into the country and has been practised on a large scale for the past

seventy or eighty years. The reasons for the failure to eliminate the disease or to reduce its incidence to negligible proportions are many, but their detailed consideration in this brief review of existing conditions does not seem justified and has, therefore, been postponed to that portion of the report which deals with smallpox.

9. Endemic diseases such as leprosy, filariasis, guineaworm infection and hookworm disease are responsible for a considerable amount of morbidity in the country, although their contribution towards mortality is relatively small. Special investigations carried out in different parts of the country have thrown light on the extent of incidence of these diseases. Such information as is available will be given in the chapter dealing with the history of the chief diseases.

10. To sum up, the present low state of the public health in India is reflected in the wide prevalence of disease and the consequent high rates of mortality in the community as a whole and, in particular, among such vulnerable groups as children and women in the reproductive age period. It is considered that at least 50 per cent. of the existing mortality in the country is preventable and should therefore be prevented.

### **CAUSES OF THE LOW LEVEL OF HEALTH IN INDIA**

11. The maintenance of the public health requires the fulfilment of certain fundamental conditions, which include the provision of an environment conducive to healthful living, adequate nutrition, the availability of health protection, preventive and curative, to all members of the community irrespective of their ability to pay for it and the active co-operation of the people in the maintenance of their own health. The large amount of preventable suffering and mortality to which reference has already been made is mainly the result of an inadequacy of provision in respect of these fundamental factors. Environmental sanitation is at a low level in most parts of the country, mal-nutrition and under-nutrition reduce the vitality and power to resistance of an appreciable section of the population and the existing health services are altogether inadequate to meet the needs of the people, while lack of general education and health education add materially to the difficulty of overcoming the indifference with which the people tolerate the insanitary conditions around them and the large amount of sickness that prevails.

The causes responsible for the present low level of health are considered below in greater detail.

#### **The Prevalence of Insanitary Conditions**

12. The wide prevalence of insanitary conditions in rural and urban areas is so well known that it seems hardly necessary to provide any evidence in support of it. Existing provision for the disposal of nightsoil and rubbish and for protected water supply will be discussed in those sections of the report which deal with them, and we need not go into these details here. But, in order to give some idea of the conditions prevailing in the rural areas, we may quote the results of certain surveys of the villages in the Punjab carried out by the Public Health Department of that

Province. The Director of Public Health took the following as criteria for what he termed a "sanitated village":—

1. a water supply protected from surface contamination;
2. drains for the removal of waste water;
3. regular removal of filth and refuse outside the village to a place prepared for their reception.

The Director of Public Health pointed out in his annual report for 1936 that, of a total of 35,871 villages in the province, only 382 villages distributed over 27 districts (or about 1 per cent.) satisfied these conditions and could be considered as "sanitated". As the result of a continued drive to improve village sanitation, the number of "sanitated" villages rose to 5,470 by 1943 or 15.2 per cent. of the total. The criteria laid down can be considered as only minimum standards of environmental sanitation and, although some progress has been achieved in this province, much more remains to be done. Similar information is not available for other provinces but there is no reason to assume that the conditions in them are in any way better than in the Punjab. Indeed, it may well be that, in some, they are worse.

### **Nutrition**

13. Defective nutrition may take two forms resulting either from an ill-balanced diet, which fails to provide the required constituents of food in their proper proportions, or from the energy value of the food being insufficient to provide for all the activities of the individual concerned; the former constitutes mal-nutrition and the latter under-nourishment. Many persons suffering from under-nourishment are also the subjects of mal-nutrition. Both these forms of defective nutrition impair the health and working capacity of human beings. Continued under-nourishment produces a state of semi-starvation. Dr. Aykroyd, the Director of the Nutrition Research Laboratories, Coonoor, has said that an insufficient and ill-balanced diet is typical of the food consumed by millions in India.

14. In India about 80 to 90 per cent. of the food consumed by the people consists of cereals. Such figures as are available suggest that the average annual production of cereals in the country in 1939-43 fell short of the necessary requirements of the population by about 22 per cent.\* In regard to other articles of diet such as vegetables, fruits, milk, meat, fish and eggs the quantities now produced will have to be increased several times before adequate amounts will become available for the proper nutrition of the people. It will thus be seen that the diet of the population as a whole is seriously defective both in quality and quantity.

### **Inadequacy of the existing Medical and Preventive Health Organisations**

15. This question may be considered from the point of view of the strength of health personnel, the number of medical institutions, the quality of service rendered by them and the bed strength available for the hospitalisation of patients.

\* Report of the Food Grains Policy Committee, Government of India, (1943) quoted by the Report of the eleventh meeting of the Nutrition Advisory Committee of the Indian Research Fund Association (March 1944).

16. Some idea of the magnitude of the task to be accomplished in increasing trained personnel of various types within the next 25 years may be obtained from the following figures:—

Class of personnel	Number available now	Ratio of numbers in column 2 to the present population of British India (300 millions)	Existing ratio in the United Kingdom	Suggested ratio to be attained in 1971 in British India with an estimated population of 370 millions	Number required in 1971
1	2	3	4	5	6
Doctors . . .	47,400	1 to 6,300	1 to 1,000	1 to 2,000	185,000
Nurses . . .	7,900	1 to 43,000	1 to 300	1 to 500	740,000
Health visitors . . .	750	1 to 400,000	1 to 4,770*	1 to 5,000	74,000
Midwives . . .	5,000	1 to 60,000	1 to 618†	1 to 4,000 (or 1 per 100 births)	92,500
Qualified Pharm. cists. . .	75	1 to 4,000,000	1 pharmacist to 3 doctors	1 pharmacist to 3 doctors	62,000
Qualified Dentists . . .	1,000	1 to 300,000	1 to 2,700	1 to 4,000	92,500

We have given existing standards in the United Kingdom but have suggested for India lower ratios as the targets to be aimed at during the next quarter of a century. The reason is that the available numbers in the various categories of personnel are so small that even the attainment of the suggested ratios by 1971 will involve concerted, intensive and unremitting effort, on an unprecedented scale, by the authorities concerned. The figures in column (2) are based on information obtained from the Provincial authorities and relate generally to 1942 or 1943. The population of British India on which the ratios in column (3) are based is estimated at 300 millions. The population in column (5) is estimated as 370 millions by the year 1971. The increase of population in British India between 1911 and 1941 was approximately 64 millions. Even if the rate of growth remains the same, the increase in a particular decade will be influenced by the size of the population at the beginning of that period, and the relatively large increase in India's population during 1921-41 may, therefore, be expected to make the absolute increase in the later decennium relatively higher. Nevertheless, it has been assumed that the probable increase during the next thirty years will not exceed 75 millions and the estimate for 1971 is therefore taken as 370 millions, as the enumerated population of British India in 1941 was about 295 millions.

17. Of the 47,400 doctors available in the country only about 13,000 are reported to be on the staff of medical institutions maintained by Governments and other agencies. The remaining

\* Based on 1935 figure.

† Based on 1943 figure.

‡ Persons who have had training acceptable in countries where legislation controlling pharmacy exists.



medical men must therefore be in private practice. The tendency is for the latter to concentrate in urban areas. For instance, in Bengal, the ratio of doctors to the population is three and a half times more in urban than in rural areas. In Sind the proportion is much higher, the doctor to population ratio in urban centres being about 49 times that for the rural areas. When it is remembered that about 90 per cent. of the total population live in villages, the extent to which provision for skilled medical aid is lacking in the country as a whole becomes emphasised.

Before any reasonably rapid expansion of health services can be carried out, the available numbers of health personnel under the different categories will have to be increased considerably. The provision of facilities for training should, therefore, have the highest priority in the health programme we put forward.

18. The average population served in each province, during 1942 by one medical institution (hospitals and dispensaries considered together) is shown below:—

Province	Average population served by a medical institution in 1942		Province	Average population served by a medical institution in 1942	
	Rural	Urban		Rural	Urban
1. Sind*	22,904	7,630	7. Orissa	52,548	15,276
2. N.W.F.P.	34,053	9,359	8. Bombay	34,927	17,127
3. Punjab	30,925	15,188	9. Bihar	62,744	18,630
4. Assam	44,562	172,962	10. C.P. & Berar	66,008	11,379
5. Bengal	37,996	19,730	11. U.P.	105,626	17,668
6. Madras	42,672	28,496			

While the extent of provision for medical relief in urban and rural areas varies considerably among the Provinces, the rural population has everywhere been less adequately provided for than the urban. The inhabitants of the rural areas live more widely dispersed than those of the urban and the medical aid given by an institution becomes to that extent more restricted. In the United Provinces there were 102,473 villages at the 1941 census and the average number of villages for a rural population of 105,626 shown in the table is 224. These figures should help to give some idea of the inadequacy of the existing provision of medical institutions.

19. Apart from the insufficient number of hospitals and dispensaries available for providing medical relief to the people, the quality of the service rendered by these institutions leaves much to be desired. During our tours in the provinces we noticed that, in most dispensaries and out-patient departments of hospitals, the time devoted to patients was so short as to make it perfectly obvious that no adequate medical service was given to the people. For instance, in one dispensary the average number of cases seen in an hour was 75. The time given to a patient, therefore, averaged 48 seconds. In another dispensary the time was about

\* These figures relate to the year 1939.

a minute. The inadequacy of the number of doctors employed is, therefore, evident. In addition, the medical officers in charge of many dispensaries have, for long periods, been out of touch with modern medical practice without an opportunity to work in a well conducted hospital, such as the better class institutions located at the headquarters of districts. The quality of the medical aid given by such men must necessarily be low. Other defects include unsatisfactory conditions in regard to the design of, and accommodation in, medical institutions, considerable overcrowding in the wards and grave insufficiency of the nursing staff.

20. We also desire to draw attention to the grave difficulties to which the poorer classes are put in securing medical aid at public hospitals and dispensaries. They frequently come from considerable distances and may have to spend a whole morning before they are seen by the doctor. The sympathetic attention and courtesy which they are entitled to expect from the hospital staff are often absent. We recognise that the great insufficiency of existing staff may, in part, explain this, but we feel bound to draw the attention of the authorities concerned to these defects in the administration of medical institutions in the interests of ensuring a better standard of service to the people. All the steps that are necessary to remove these defects should be taken without delay. Apart from the fact that the poorer sections of the community have the right to demand fair treatment at the hands of the hospital staff, we feel that the one condition which we have stressed for ensuring the success of the future health programme, namely, the active support and co-operation of the people in the day-to-day functioning of the organisation, cannot be fulfilled without a radical change in the existing state of affairs.

21. The number of beds available in British India, including those for the treatment of general and special diseases, is about 73,000 or about 1 bed to 4,000 of the population. The following figures compare British India with England and Wales and the United States of America in this respect:—

U.S.A.	10.48	beds per 1,000 population.
England and Wales	7.14	„ „ 1,000 „
British India	0.24	„ „ 1,000 „

22. The question may be considered from another point of view. In England it has been estimated that, with the existing morbidity and mortality rates, the minimum standards should be 10 beds per 1,000 of the population. On this basis the number of beds required for India will be over 40 times the present provision. When it is remembered that the mortality rate in England is only half that of India and that the morbidity rate in the latter is, therefore, bound to be much higher than in England, adequate institutional care would seem to require an expansion of hospital accommodation which may well be about 80 or 90 times the present provision.

23. Some idea of what can be achieved in increasing hospital accommodation can be obtained from what has been done in Soviet Russia within a period of about a quarter of a century. In 1914

the number of beds per 1,000 of population was 0.98. By 1940 it had risen to 4.66, an increase by over four and a half times.

24. As regards the preventive health organisation, a certain number of provinces have District Health Officers in charge of rural health administration in all their districts, some others have such officers only in a limited number of districts, while the remaining provinces have the Civil Surgeon in combined charge of medical and public health activities. The extent to which health officers have been appointed in municipalities also varies widely in the provinces. The total number of sanitary or health inspectors employed in British India is about 3,000 while it has been estimated that the number required will be in the neighbourhood of 12,000. The existing number of midwives is probably 5,000, while, for adequate service to the people, 100,000 are considered necessary. The total number of health visitors in the country is about 700 or 750 while, for the supervision of the work of 100,000 midwives about 20,000 health visitors will be required. The number of woman doctors with special training in maternity and child welfare work is about 70 or 80 and, of these, only a dozen are women graduates in medicine with adequate special training in maternity and child welfare work.

25. Thus it will be seen that the existing organisations for curative and preventive health work in India are altogether inadequate for the tasks with which they are confronted. On the medical side, the existing staffs are hardly able to do anything more than struggle with the large numbers of patients crowding into hospitals and dispensaries. On the public health side, the energies of the skeleton staff employed in the provinces have, so far, been concerned mainly with measures for the control of epidemic diseases, and even this task is being performed with insufficient results. A wide expansion of the curative and preventive health services should therefore form an important part of our programme of future health development in the country.

### **General Education and Health Education**

26. The purpose that general education has in view is to develop the individual into a useful citizen; the purpose of health education is to inculcate the principles of healthful living in order to secure the full co-operation of the individual in the maintenance of his own health. Without general education the task of imparting instruction in health matters becomes difficult. Apart from the handicap that illiteracy places on health education by restricting the methods of appeal to the spoken word or to visual demonstration, education in its wider sense is essential in order to promote a general raising of the standard of culture in the community and to quicken the sense of civic responsibility of the individual. The insanitary conditions associated with rural and urban life in the country can, to a large extent, be mitigated if the individual feels a sense of responsibility towards his neighbour. Speaking generally, while the Indian home is kept fairly clean, the sense of responsibility of the average person in regard to

community hygiene seems not infrequently to be conspicuous by its absence. It is clear that the development of civic consciousness is essential if an improvement of environmental hygiene is to be effected. The importance of general education and health education for creating this civic consciousness cannot be over-emphasised.

27. The percentage of literate persons in British India at the 1941 census was only 12.5. Apart from this low figure, the quality of general education now imparted in primary schools is of a very low standard and a large proportion of the persons, whose educational career terminates at the primary school stage, lapses into illiteracy.

28. As regards health education, the low standards of personal and environmental hygiene met with among large sections of the people in urban and rural areas indicate that the measures so far taken to educate them in the hygienic mode of life will have to be strengthened considerably if their co-operation is to be secured for the maintenance of their own health and for keeping up a high standard of community hygiene.

#### **The Social Background of Ill-health**

29. In addition to the causes for the low level of health discussed in the preceding paragraphs mention should be made of certain social factors which are also important in this connection. These include unemployment and poverty and certain social customs such as the *purdah* and early marriage. Further, the people view with apathy the large amount of preventable sickness and mortality which exists in their midst and this outlook has no doubt been largely due to the continuance of the existing state of affairs through many generations, to which the inadequacy of the available health services has been an important contributory factor. Measures designed to change this outlook are essential, if a definite improvement in the public health is to be achieved.

30. Unemployment and poverty produce their adverse effect on health through the operation of such factors as inadequate nutrition, unsatisfactory housing and clothing and lack of proper medical care during periods of illness. While recognising that it is not within the scope of our enquiry to suggest ways and means by which poverty and unemployment should be eliminated, we feel that our survey of the causes of ill-health in India will not be complete without drawing attention to the profound influence that these factors exert on the health of the community. In a reaffirmation of the principles regarding health policy in connection with discussions on the Beveridge report, the British Medical Association emphasised that "the health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities, and upon the facilities for exercise and leisure".\*

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\* British Medical Journal for 7th August 1943.

31. The effects of the *purdah* on the health of those who observe this custom are perhaps more marked in respect of tuberculosis than any other disease.\* In a paper entitled "Tuberculosis in the Zenana"† dealing with this problem in Ludhiana, Dr. Rose A. Riste, Director of Tuberculosis and X-Ray Departments of the Women's Christian Medical College, Ludhiana, Punjab, has given evidence of the effect that this custom has on the incidence of the disease.

"The earlier seclusion, including the *burqa*, of the Mohamadan girl shows its effect in the earlier rise of her tuberculosis death rate, to 44.46 in the 10 to 14 age group as against her Hindu sister's, 18.81. Their brothers' rises were slight: to only 6.88 for the Mohammedan youth and to 12.70 for the Hindu. A few years later, during the universally critical period of child-bearing, practically all members of these *purdah* families get the full effect of their seclusion, and their death ratio soars."

32. As regards early marriage no information is available from the 1941 census. At the 1931 census a rather unusual phenomenon was observed, namely, that the proportions of married males and females under 15 years of age, which had steadily decreased at each successive census after 1881, suddenly showed increases in 1931. The relevant figures are quoted from the Census of India, Volume I, Part I, 1931.

*Number of married per 1,000 of those aged 0-15 years*

Sex	1881	1891	1901	1911	1921	1931
Males . . . . .	63	59	59	54	51	77
Females . . . . .	187	170	162	156	144	181

This sudden rise was stated by Dr. Hutton, the Census Commissioner, to have been "due to the enormous number of infant marriages which took place in the six months' interval between the passing of the Sarda Act and its coming into operation". He also stated, that, in many cases, "the children married in all

\* In our opinion the views expressed about the effects of *purdah* on the health of those who observe this custom are erroneous and based upon insufficient information of the practice of *purdah*. To our knowledge no scientific investigation has so far been carried out anywhere in India to evaluate the effects of *purdah* alone on health generally and rate of incidence of tuberculosis particularly.

The extract quoted from the report of Dr. Riste seems to us to be based upon entirely insufficient data, as we feel that there are several very important factors which may be responsible for the rise in the incidence of tuberculosis in that particular age group of Muslim girls as against their Hindu sisters of the same age group, which do not seem to have been taken into account.

A. H. BUTT,  
KHADIJA SHUFFI TYABJI,  
M. A. HAMEED.

† Indian Medical Gazette, September 1938.

this haste were the merest infants". The Sarda Act came into force on 1st April 1930 and it made the minimum age for marriage for girls 14 years, which is too low for placing the strain of maternity on a growing girl. A social custom which impelled the people to marry even infants in anticipation of legal prohibition dies hard and, although no later information is available regarding the age distribution of married women, it may not be unreasonable to assume that child marriages in close proximity to the permissible age of 14 must still be common in the country. The ill-effects of child marriage on the mother's health are indicated in the following figures for maternal mortality quoted from a report on an investigation into the subject carried out about 17 years ago in Madras Presidency by the Provincial Public Health Department.

* Age period	Maternal death rate per 1,000 confinements.
Under 15	46.51
15 to 19	23.74
20 to 24	17.91

33. The higher risk of maternal mortality at the lower age periods is clear. Death is often only the final release from a period of suffering and incapacitation. The higher death rate for girl mothers is bound to be accompanied by a larger proportion of cases suffering from varying degrees of discomfort and disablement in comparison with child-bearing women at later ages.

34. No measures designed to improve existing conditions can produce lasting success unless the people are aroused from their apathy to tolerate the insanitary conditions around them and the large amount of sickness that prevails, can be overcome. Towards this end it is desirable that the people should be associated with the measures that are undertaken for the improvement of their health. A spirit of self-help should be created among the people through the development of co-operative effort for the purpose of promoting curative and preventive health work. In the programme of health development, which we put forward, the need for securing the active co-operation of the people in the day to day functioning of the health organisation should be prominently kept in view.

35. To sum up, the factors responsible for the low level of ill-health in India include, among others, the prevalence of mal-nutrition and under-nutrition among appreciable sections of the people, the serious inadequacy of existing provision for affording health protection to the community and a group of social causes consisting of poverty and unemployment, illiteracy and ignorance of the hygienic mode of life and certain customs such as the *purdah* and early marriage. The cumulative effect of these factors

\* Quoted from the "Report on an Investigation into the causes of Maternal Mortality in the City of Madras" by Dr. (now Sir) A. Lakshmanaswamy Mudaliar.

is seen in the incidence of a large amount of preventible morbidity and mortality in the community. The continued prevalence of such conditions for many generations has probably helped to create in the minds of the people an attitude of passive acceptance of the existing state of affairs. This attitude will have to be overcome and their active co-operation enlisted in the campaign against disease, insanitation and undesirable personal and community habits, if any lasting improvement in the public health is to be achieved.



सत्यमेव जयते

## CHAPTER II.

### HISTORY OF HEALTH ADMINISTRATION IN INDIA

#### **Administrative Organisations at the Centre, at the Headquarters of Provincial Governments and in Local Areas and their Inter-relationships**

##### **Introduction**

1. The early efforts of health administrations were directed to the alleviation of suffering and to the rehabilitation of the sick. The idea of prevention came later, partly as the result of the observation that diseases were often communicated from the patient to those in close association with him. Thus arose the conception of segregation of the sick and of the enforcement of quarantine against those who were in contact with patients. These measures were carried out in Europe and Asia against diseases such as plague and leprosy many centuries before the causes for their incidence had become known.

2. In the early days, the enforcement of such preventive measures was sought to be achieved mainly by incorporating these practices in the life of the community and by strengthening their observance through the compelling force of religious sanction. The provision of medical aid to the people developed mainly as a doctor-patient relationship, without an attempt to organise the service on the basis of meeting the requirements of the community as a whole. Religious organisations had frequently a prominent part to play in the establishment of such treatment facilities and the range of ministration was generally restricted to limited sections of the population. The modern conception of a simultaneous application of preventive and remedial measures to maintain the health of the individual and of the community was absent in those days. Nor was there an adequate recognition of the role that environmental hygiene plays in the preservation of health. The reasons for these are not far to seek. It was the development of modern sciences, such as bacteriology, parasitology and pathology, in the latter half of the last century which brought to the forefront the importance of specific organisms as the causative agents for individual diseases and indicated clearly the particular modes of spread of these diseases. The gradual evolution of rational methods for their control was a natural sequel to the development of such knowledge. The recognition that patients were active disseminators of infection has led to the acceptance of the need for their segregation and treatment. The prevention of the spread of infection from the patient to those who are healthy requires, in many cases, active interference by man with the natural environment, in order to control the multiplication of insect and other carriers of infection or to remedy the harmful effects of contamination of air, water and food by material likely to cause disease, whether it be derived from human or other sources. It has thus become recognised that the coordinated application of curative and preventive measures can alone help to secure an adequate control over the incidence of disease. This remark applies not only to conditions of ill-health in which invasion by an outside organism is the main causative factor but also to those diseases, such as diabetes or gout, where a derangement of the normal functioning of the body is the principal cause. In such cases a change in the previous mode of



life of the patient is essential and preventive health work now includes, in addition to environmental hygiene on the lines already indicated, education of the patient to the adoption of the desired changes in his habits. This comprehensive conception of what a community health service should undertake has led to the development of modern health administration, in which the State makes itself responsible for the establishment and maintenance of the different organisations required for providing the community with health protection on the wide basis indicated above. It is clearly beyond the capacity of individuals or of groups to secure for themselves these facilities from their own resources. Moreover, the enforcement of many of these measures requires legal sanction and governments are alone in a position to arm themselves with the necessary legal powers.

3. It will thus be seen that the active promotion of the public health is a comparatively modern conception. We believe that Great Britain led the way in the development of health administration, both in its legislative and administrative aspects. It is less than one hundred years since, in that country, legislation towards the control and improvement of the health of the individual and the community acquired, in the words of the great exponent of Preventive Medicine Dr. (later Sir) John Simon, "the virtue of the imperative mood". In that country and in the West generally the latter half of the nineteenth century saw, as has already been pointed out, a growth in knowledge in all branches of medical science far beyond anything that had occurred in the previous centuries. The assimilation and application of this knowledge even in Europe were a gradual process. In India the rate of progress in health administration has been much slower. We shall describe briefly below the successive stages of its development. Before doing so, reference may be made to one aspect of health administration in which India differs from other countries. In the latter the provision of medical relief for the community has largely developed in the past through the efforts of voluntary agencies and through the growth of an independent medical profession. In India, on the other hand, medical relief was accepted by the State as its responsibility from the beginning. Indeed, it received much more attention than the development of those preventive health measures which may collectively be termed "public health activities". In the paragraphs that follow we shall confine attention to the development of public health administration as apart from medical administration.

#### **The Development of Public Health Administration in India**

4. We may refer to four landmarks in the history of public health administration in the country. These are:

- (1) the appointment of a Royal Commission to enquire into the health of the army in India in 1859;
- (2) the report of the Plague Commission in 1904 following the outbreak of plague in 1896;
- (3) the Reforms introduced by the Government of India Act of 1919 and
- (4) the Reforms introduced by the Government of India Act of 1935.

5. The Royal Commission of 1859, which was appointed to enquire into the conditions of health of the army in India recommended measures not only for the army but also for the civil population. In accordance with its suggestions "Commissions of Public Health" were established in the provinces of Madras, Bombay and Bengal in 1864. The Commissions in Madras and Bengal put forward far-reaching recommendations, which included the employment of trained public health staffs in towns and in districts. But these recommendations were not carried out and no comprehensive policy in regard to the development of preventive health services was laid down. Certain administrative posts were, however, created at the Centre and in the Provinces. The officers concerned were designated Sanitary Commissioners. In addition to advising Governments and local bodies on sanitary matters these officers were entrusted with the control of vaccination against smallpox in their respective areas. In 1888, in view of the recent creation of local bodies, municipal and rural, the Government of India "issued a resolution drawing the attention of local bodies and village unions to their duties in the matter of sanitation". The success achieved by such efforts was, however, negligible except in the larger cities. Each provincial Sanitary Commissioner had only one assistant to work with him and, apart from this lack of adequate technical staff, the main emphasis continued to be laid, during the period, on the development of medical relief. Medical administrators did not give preventive medicine its proper place. We recognise that, for this, there was some excuse. The vast numbers of India's sick presented a field so obviously demanding attention that it was to the practice of curative medicine that, by far, the majority of the doctors in the State health service turned. Lay administrators, therefore, naturally tended to regard provision for hospital facilities and attention to the sick as of more importance than arrangements to meet the fundamental requirements of the community and the individual in regard to environmental hygiene. Without these requirements being met, the attempt to cure the sick of a continent, though embarked upon courageously, was doomed to failure.

#### **The Outbreak of Plague in India in 1896 and the Report of the Plague Commission in 1904**

6. The outbreak of plague in India in 1896 had a great effect on the people and on Government. We may quote in this connection the remarks of a former Sanitary Commissioner with the Government of India:—

"When plague appeared it was not a new disease to India, but it was new to the present generation of Indians and it has exacted a very heavy toll of deaths all over the country. The strangeness of the disease, the unpopularity of the measures taken to control it and impotence of these measures, have served to rouse the people from their apathy and concentrate the attention of all, but especially of the educated classes, on sanitation in a way that nothing else could have done. The more enlightened have begun to grasp the fact that much of the present sickness is preventable

and much of the mortality unnecessary, to realise in short the importance of sanitation, the economic value of health and the wastefulness of sickness and premature death. This is shown by their demand for better water, better food, better housing, better drainage. The movement once started will certainly increase and gather force..... At the same time plague has not been without its effect on Government. Previous to the advent of this disease it had been the generally accepted opinion that sanitation was the work of any medical officer and required no special training. A special sanitary staff had therefore not been considered of any very great importance. When plague appeared the staff was inadequate and unprepared; action was taken on general principles and sanitary measures were adopted, which, with further study of the etiology, we now know, were unsuitable and could do little to check the spread of the disease. The waste of life, time, money and effort that resulted has impressed on Government the necessity of being prepared in future."

7. The report of the Plague Commission in 1904 recommended the strengthening of the public health services and the establishment of laboratories for research and for the preparation of vaccines and sera. The action taken to implement those recommendations included the creation of a Medical Research Department under the Central Government, the establishment of the Indian Research Fund Association for promoting research into medical problems and annual grants from the central funds to the provinces to assist in the execution of public health works, such as drainage and water supply, and in the strengthening of public health personnel by additions to the existing posts of Deputy Sanitary Commissioners under Provincial Governments and of health officers under local bodies. But the total effect of such measures on the health problems of a sub-continent like India was necessarily small. Attention was directed mainly to urban centres while about 90 per cent. of the country's population lived widely dispersed in villages. Unless the preventive health organisation could be brought as close to this large section of the community as possible, there was little chance of any appreciable reduction in the incidence of preventable morbidity and mortality.

#### **The Reforms introduced by the Government of India Act of 1919**

8. As far back as 1914 the Government of India stated that its policy was to keep the control of research under itself but to decentralise other branches of health administration by transferring them to Provincial Governments. The Government of India Act of 1919 gave statutory sanction to this transfer of functions. Medical administration, including hospitals, dispensaries and asylums and provision for medical education, public health and sanitation and vital statistics, with certain reservations in respect of legislation by the Indian Legislature, were transferred to the provinces. In addition, in the provinces Ministers responsible to the legislature were entrusted with the administration of such departments as health, education, agriculture and cooperation. The results of these changes were of a marked character. The

Ministers were anxious to promote the growth of education, medical relief and preventive health measures as far as funds permitted. The establishment of trained public health staffs for rural and urban areas which the "Commissions of Public Health" had recommended in the sixties of the last century was taken up in earnest and, after the introduction of the Reforms of the 1919 Government of India Act, the organisation of such services was a marked feature in a number of provinces. Indeed, there has been, since that time, far greater public health activity in the provinces than ever before.

9. The administrative changes brought about in the provinces by the 1919 Act were also accompanied by certain detrimental effects. These are mainly in the field of local body health administration and we shall deal with them in the section relating to that subject.

10. The health functions of the Centre became reduced, under the Act, mainly to India's international health obligations, including port quarantine and marine hospitals, the census and legislation in respect of certain subjects such as the interprovincial spread of infectious disease.

#### **The Reforms introduced by the 1935 Government of India Act**

11. Under this Act the distribution of health functions between the Centre and the Provinces has remained practically unaltered. At the same time, a larger measure of autonomy has been granted to the Provinces than in the Government of India Act of 1919, with the result that the Provincial Legislatures and Provincial Governments are unfettered in the development of internal health policy and its implementation. It is against this background of an existing demarcation of health functions between the Centre and the Provinces that we shall have to consider our proposals for the development of health administration in India.

12. Under this Government of India Act there are three lists of subjects for legislation, (1) the Federal Legislative List, (2) the Provincial Legislative List and (3) the Concurrent Legislative List. The subjects included in the first and second lists conform broadly to the division of functions between the Centre and the Provinces, which we have briefly indicated above. The Concurrent List consists of two parts. Part I includes such subjects as the medical profession, lunacy and mental deficiency, and poisons and dangerous drugs. Part II includes factories, the welfare of labour and prevention of the extension of infectious and contagious diseases from one unit of the Federation to another. In regard to the subjects under the Federal and Provincial Lists, the executive power is vested in the Central and Provincial Governments respectively. In respect of those under the Concurrent List, the executive power is vested in the Provincial Government. For the subjects under Part II of this list, the Central Government will, however, have the power of giving directions to the provinces if the necessary provision for this purpose is made in the ~~Central Act dealing~~ with any of these subjects.

### Health Administration at the Centre

13. Until quite recently, the Central Government used to exercise its main health functions, so far as the civil population is concerned, through the Department of Education, Health and Lands. On 1st September 1945 a separate Health Department was constituted, thus fulfilling partially a recommendation which we have made in this report. We understand that, while a separate secretariat is now in charge of health matters, the Minister responsible for the portfolio of health has also other subjects to deal with. We have recommended that there should be a Minister who can devote undivided attention to health administration alone.

14. Certain other departments of the Government of India are also concerned with health functions in specific fields, in pursuance of the responsibilities of the Centre under the Federal and Concurrent Lists. For instance, the Labour Department deals with factories and the welfare of labour, the Finance Department with dangerous drugs and opium, the Home Department with lunacy and mental deficiency and poisons, and the Defence Department with the health administration of cantonments. Further, the Railway Board is concerned with the health of railway employees.

15. We shall now indicate, in some detail, the functions of the Central Health Department. These include the following subjects in the Federal and Concurrent Legislative Lists:—

- (1) federal agencies and institutes for research, for professional or technical training or for the promotion of special studies where the research, training or special studies are related to medicine or public health;
- (2) port quarantine; seamen's and marine hospitals and hospitals connected with port quarantine;
- (3) the medical profession and other professions whose activities are related to medical relief and public health, *e.g.*, the nursing profession, the pharmaceutical profession, the profession of dentistry and
- (4) the prevention of the extension from one unit to another of infectious or contagious diseases.

16. This Department also deals with those subjects in the Provincial Legislative List which are shown below, in so far as the Centre may be concerned:—

- (1) public health and sanitation; hospitals and dispensaries; registration of births and deaths;
- (2) local government;
- (3) education, medical and public health;
- (4) supply and distribution of cinchona and quinine;
- (5) adulteration of foodstuffs and drugs and
- (6) scientific societies concerned with medicine and public health.

**The Technical Health Organisation at the Centre**

17. On the technical side the Member in charge of the Health Department has two advisers, the Director General, Indian Medical Service, and the Public Health Commissioner with the Government of India.

18. The Director General, Indian Medical Service, advises the Government of India on all questions of a medical nature. He, as head of the Indian Medical Service, is responsible to see that that Service is kept up to its strength. He advises Government on the promotion of officers to the administrative posts. In peace time his technical staff consists of two assistants, a Deputy Director General, Indian Medical Service, who is responsible to the Director General for the administration of the office establishment and an Assistant Director General, who is in administrative control, under the Director General, of the civil medical stores depots. The Public Health Commissioner with the Government of India acts, in addition to his main duties, as Staff Officer on public health matters to the Director General, Indian Medical Service.

19. The Public Health Commissioner is the adviser to the Government of India on all public health matters including those relating to India's international health obligations and the medical aspects of overseas pilgrim and emigration traffic, and he is responsible to that Government for health administration at air and sea ports. He is also responsible for the consolidation and issue of vital statistical returns for British India as a whole and for an annual report to the Government of India on the health of the country. He used to be normally the representative of the Government of India on the Office Internationale d'Hygiene Publique in Paris and on the Health Committee of the League of Nations in Geneva. He has ordinarily two technical assistants, a Deputy Public Health Commissioner and an Assistant Public Health Commissioner.

20. Both the Director General and the Public Health Commissioner are closely associated with the promotion of medical research in India. The former is the administrative head of the Medical Research Department maintained by the Government of India, while the latter is mainly responsible for its actual administration under the control of the Director General. In the Indian Research Fund Association, which is the largest body concerned with the promotion of medical research in India, both hold important positions. They are members of the Governing Body of the Association. The Director General is the Chairman of the Scientific Advisory Board of the Association, which controls the scientific aspects of research and recommends the sanctioning of grants for specific enquiries. The Public Health Commissioner is the Secretary of the Association and of its Governing Body as well as of the Scientific Advisory Board. He is also in charge of the day to day administration of the Association.

21. In addition to these duties, the two officers participate in the health activities of a number of voluntary organisations, either as chairmen or as members. These organisations include the Indian

Red Cross Society, the Tuberculosis Association of India and the Indian Councils of the St. John's Ambulance Association and the British Empire Leprosy Relief Association. In addition, these officers are also members of certain committees concerned with the direction of special fields of health activity such as the Central Committee of the Pasteur Institute of India, the Governing Body of the School of Tropical Medicine, Calcutta, and the Countess of Dufferin Fund. Either one or both of them are on all these Committees. It will thus be seen that, apart from the technical advice they place at the disposal of the Central Government and of the Provincial Governments, if so desired by the latter, they are able to assist in promoting the activities of a number of organisations. The first four voluntary organisations are engaged in advancing their specific forms of health work on an all-India basis through a number of branches in the Provinces and States.

### **The Need for Coordination of Central and Provincial Health Activities and the Establishment of the Central Advisory Board of Health**

22. As has already been stated, the provinces are autonomous in regard to all matters relating to internal health policy and administration. This position has been in existence, to a large extent, since 1921 when the Government of India Act of 1919 was brought into operation. Since that time the importance of providing machinery for coordinating the health activities of the Centre and the Provinces became increasingly evident as the years elapsed. In the circumstances, when the Government of India Act of 1935 was brought into force in April 1937, the Government of India decided that the time had arrived to establish an organisation for bringing together the Centre and the Provinces on a common platform to discuss health matters. It was also recognised that such discussions should bring, within their scope, the Indian States, because the contiguity of their territories with British India created common problems and interests in health matters. In June 1937 the Government of India established the Central Advisory Board of Health for this purpose under the chairmanship of the Member in charge of Health in the Viceroy's Executive Council and with members consisting of the Health Ministers in the provinces and of representatives from a certain number of Indian States (at first three States, later increased to four). In addition to the Member in charge at the Centre, the representatives of the Government of India include the Director General, Indian Medical Service, the Public Health Commissioner and representatives of the Defence and Railway Departments, because the health problems of the civil population are often closely associated with those with which these departments are concerned. A woman member is also generally nominated by the Government of India. The Board has so far held five meetings at intervals of about 18 months. Various matters of common concern in regard to health administration were discussed at these meetings and decisions (practically unanimous on all occasions) were reached. In addition, the Board has made definite contributions to the study of specific health problems through the reports of the special committees appointed by it to

investigate such problems. While, therefore, a certain amount of valuable work has been done, the recommendations made by the Board have, unfortunately, been carried out only to a very limited extent. For this the adverse conditions arising out of the war are partly responsible. But we believe that there is another reason also. Health planning and its execution must, in our view, be a continuous process and, in this process, the nature and range of cooperation between the Centre and the Provinces will have to be something more than the exchange of views which the meetings of the Board have so far provided. If our proposals for health development in the country are to be successfully implemented, active cooperation and assistance must take the place of academic discussions at such meetings. While we must defer, to the next volume of our report, a discussion of the measures which we consider necessary to develop and maintain such cooperation, we may mention here our view that the Centre will have to assist the Provinces with financial aid and technical advice in regard to their health schemes, if any reasonably rapid advance is to be effected. We mention this only to point out that the provision of suitable technical advice by the Centre will necessitate the employment of a much larger staff than the meagre establishments that now exist in the offices of the Director General and Public Health Commissioner. Health administration has, indeed, become so ramified as the result of developments in various fields that adequate technical competence in specific spheres of activity can be attained only by prolonged specialisation.

### Central Health Legislation

23. Legal provisions regarding health matters are scattered over some 40 and odd enactments dealing with diverse subjects. Examples are the Quarantine Act, 1825, the Indian Merchants' Shipping Act, 1859, the Indian Penal Code, 1860, the Vaccination Act, 1880, the Medical Act, 1886, the Indian Railways Act, 1890, the Births, Deaths and Marriages Registration Act, 1896, the Epidemic Diseases Act, 1897, the Code of Criminal Procedure, 1898, the Glanders and Farcy Act, 1899, the Indian Factories Act, 1911, the Indian Steam Vessels Act, 1917, the Indian Red Cross Act, 1922, the Indian Mines Act, 1923 and the Cantonments Act, 1924. These legal provisions were made on different occasions to meet varying requirements and their administration is often in the hands of different authorities. A programme of future health development should take into consideration the need for, and the possibility of, bringing together as many of the health functions as possible under a unified authority such as a Ministry of Health and of so relating the exercise of health duties still left for administration by other authorities, to the general health administration of the country as to permit of the enforcement of desirable minimum standards of performance in the different spheres of activity and of the pooling of all available resources in personnel and material. For instance, in any area, a coordinated programme of development of the health services for the general population, industrial workers, prisoners and railway employees can avoid



unnecessary waste of public funds through the duplication of institutions, personnel and equipment in many directions and such a programme will also probably promote efficiency. To serve these purposes it may be necessary to enact a comprehensive Public Health Act. Existing health legislation in various enactments can be included in such an Act and, where necessary, amendments and additions can be incorporated in order to meet the growing needs of modern health administration.

### **The Centrally Administered Areas**

24. Delhi Province, Coorg, Ajmer-Merwara and Baluchistan are under the control of the Central Government and are known as Centrally Administered Areas. The health administration of these areas, more particularly of the last three, generally leaves much to be desired. Mention should be made of the serious attempt made to control malaria in the Delhi urban area with a large measure of success.

### **Health Administration in a Province**

25. Provincial health administration is, under normal conditions, in charge of a Minister responsible to the Legislature. As in the case of the Centre this Minister has generally charge of the administration of a number of other departments also. He has two technical advisers who are responsible, subject to his control, for the administration of the Medical and Public Health Departments respectively. In the three provinces of Madras, Bombay and Bengal the former is called the Surgeon General and in most of the other provinces, the Inspector General of Civil Hospitals. The Officer in charge of the Public Health Department is known as the Director of Public Health. In the North-West Frontier Province these posts are combined while, in each of the two most recently created provinces of Orissa and Sind, a single officer controls medical and public health activities for the general population as well as the health administration of jails. He is designated the Director of Health and Prison Services. In all the other provinces the health administration of jails is in the technical charge of a separate officer, the Inspector General of Prisons, who works under the provincial Minister in charge of prisons.

26. Under certain existing rules the post of the head of the civil medical service in the Governors' Provinces is reserved for a certain class of officers in the Indian Medical Service. The right of choosing the incumbent of this post rests with the Provincial Government, but the selection has to be made from a panel of names drawn up by the Central Government. As regards the Director of Public Health, the position is different and the Provincial Government may appoint, at its discretion, either an Indian Medical Service officer or an officer belonging to the Provincial Public Health Service.

27. Under the provisions of Section 246 of the Government of India Act, 1935, a certain number of posts in the provinces has been reserved by the Secretary of State for members of the Indian

Medical Service. It is understood that one of the reasons underlying such reservation is the acceptance, by the Secretary of State, of the principle that British officers in civil employment under the Crown should be ensured medical service by British medical personnel.

It may also be mentioned that a certain number of posts under the Central Government has also been reserved for the civil branch of the Indian Medical Service under section 246 of the Government of India Act, 1935.

28. While, in certain provinces, the preventive health service has undergone a considerable development during the past two decades, in others no such expansion has taken place. The latter, while they have a Director of Public Health and a few assistants to help him, have not yet organised health staffs for rural and urban areas in the districts. In these provinces, preventive health duties form part of the responsibility of the Civil Surgeon in each district. The duties of the latter in connection with medical administration as well as his professional work in the district headquarters hospital and his private practice generally take up so much time that the public health functions, which he is required to perform, remain largely undischarged. We shall content ourselves here with this brief reference to the differences between individual provinces in respect of the public health service and shall describe in a separate chapter, the existing organisations for preventive and curative health work in the provinces and the extent to which they are able to fulfil the tasks that are expected of them.

### **Provincial Health Legislation**

29. In the provinces also, legal provision in regard to health matters lies scattered over a number of Acts, and there is therefore need for the enactment of consolidated Public Health Acts in the provinces also. At present there is only one province (Madras) which has a comprehensive Public Health Act satisfying reasonably the requirements of modern health administration.

### **The Relationship between the Curative and Preventive Departments of Health**

30. We may at this stage digress to review briefly the relationship between the curative and preventive departments of health both at the Centre and in the Provinces.

31. At the Centre the Public Health Commissioner deals directly with the Government of India in matters relating to international health and he is responsible to that Government for sea and air port health administration. In these and in the collection and publication of epidemiological information from the provinces, he functions in an independent capacity and is not subject to the control of the Director General. On the other hand, he acts as a "staff officer in public health" to the Director General as regards the administration of the Medical Research Department and certain institutions maintained by the Central Government. Again, in respect of research, there is close relation between these officers, as the Director General is the Chairman and the Public

Health Commissioner the Secretary of the Scientific Advisory Board of the Indian Research Fund Association. At the Centre the position seems therefore to be that, while the Public Health Commissioner is independent of the Director General in respect of health matters generally, he is, in certain respects, subordinate to that officer. While there exists some difference between individual provinces in the relationship between the officers in charge of the two departments, the position is, broadly speaking, that the two departments function independently of each other. With the large expansion of the Public Health Department in a number of provinces after the introduction of the Reforms under the 1919 Government of India Act, the independent existence and separate functioning of the two departments have become well established in such provinces. Before the expansion took place the Civil Surgeon was in charge of both curative and preventive duties and, if there was a recognition of the need for developing public health work (as in the case of the province of Madras), the method adopted to deal with the extra work was to give the Civil Surgeon a Sanitary Assistant with the status of an Assistant Surgeon in the provincial medical service.

32. The separation of the two departments has, in our view, helped to secure greater attention and support for the relatively new and developing preventive health service. At the same time, with the lapse of years, the results of their working independently of each other and of the consequential incoordination of effort are becoming more and more evident. In many branches of health activity the curative and preventive aspects cannot be separated without lowering the efficiency of the service to the people. For instance, a maternity and child welfare organisation cannot be built up on satisfactory lines without including in it the service which health visitors and midwives give in the homes of the people as well as the facilities for diagnosis and treatment required in respect of many forms of maternal ill-health and for the institutional care of difficult cases of childbearing, which the medical department can provide. These remarks apply equally to the control of infectious diseases, including tuberculosis, leprosy and venereal diseases. Even in those provinces in which the preventive health service has been best developed, the existing organisations are so understaffed and so ill-equipped with institutional and other facilities that the service they are able to offer to the people is of a very low standard. If the two departments are to function separately an unnecessary duplication of institutions, personnel and equipment seems inevitable, if reasonable standards of service are to be attained. In putting forward our proposals for the country's future health service, the question will therefore have to be considered as to whether the two departments should continue to work separately or whether they should coalesce into a single organisation.

#### **Health Administration in Local Areas**

33. Local bodies are responsible for health administration in their respective territories. The legal provisions defining their duties and powers are incorporated in the Self-government Acts

which have brought them into existence. Large municipal corporations such as those of Calcutta, Bombay, Madras and Karachi have been constituted by special Acts. Other municipalities in the provinces, in which these cities are situated, and all municipalities in other provinces are governed by a single municipal Act in each province, passed by the Provincial Legislature concerned.

34. District Boards constitute the local authorities for the non-municipal areas in the districts. In some provinces, *e.g.*, the Punjab and Bombay, Local Boards, whose jurisdiction covers a limited part of the District Board area, also exist and these are subordinate to the District Boards. In addition, smaller units of local self-government, such as Village Panchayats exist in certain provinces and Union Boards in others. These are subject to the control of the District Board.

35. Broadly speaking, the powers conferred on these authorities in respect of health matters relate to general sanitation, control of infectious disease, regulation of housing construction, control of the purity of food and water supplies, abatement of nuisance and registration of vital statistics. The health duties and powers conferred on the different types of local bodies vary, however, to a considerable extent. Municipal authorities have generally larger powers than rural local bodies.

36. Speaking generally, all local bodies have the power to appoint and control their own establishments, including the health staff. In certain provinces, however, Provincial Governments have made themselves responsible for the maintenance of cadres of health officers for both urban and rural areas, *e.g.*, Madras and the United Provinces. In the Punjab provincialisation of the service of health officers has been carried out only in respect of the rural areas. In those provinces in which local bodies appoint their own health officers, control by the Provincial Government is ensured by the statutory requirement that the prior sanction of the latter should be obtained for their appointment or dismissal. Other members of the public health staff maintained by local bodies are generally appointed and controlled by the local authorities themselves.

37. The general level of efficiency of health administration by local bodies is low. Some of the causes which contribute to this state of affairs are:—

- (1) the financial resources of these bodies are, in the majority of cases, insufficient to maintain adequate services staffed with well qualified personnel;
- (2) the executive power is generally vested in an elected Chairman who often finds himself powerless to enforce the law against vested interests in the absence of a public opinion sufficiently strong to demand such enforcement in the interests of the community and
- (3) the local health officer and the Provincial Director of Public Health can only give advice to the Chairman and cannot ensure that such advice will be carried out even where it is urgently required in the public interest, as in the case of measures to control epidemics.

38. It may be mentioned that legislative and administrative measures taken by the Government of Madras have helped to remedy such defects to a large extent in that province. For instance, the executive powers of the Chairmen of municipalities in the field of general administration have been transferred statutorily to Commissioners appointed and controlled by the Provincial Government. The executive powers relating to health administration have been transferred to the local health officer. The Director of Public Health has been empowered to make recommendations to local bodies regarding the measures he considers necessary to improve local health administration and, subject to the concurrence of the Provincial Government, he is entitled to enforce the execution of these recommendations by the local authorities concerned. As regards expenditure on local health administration, municipalities are required to set aside 30 per cent. and district boards 12½ per cent. of their respective annual revenues for this purpose.

39. The ultimate responsibility for the improvement of local health administration rests on the Provincial Government concerned, administration rests on the Provincial Government concerned, which has been given by the Provincial Legislature considerable powers of supervision and control over the administration of local bodies. It can also acquire any further powers that may be required. Madras has shown the way as to how, through combined legislative and administrative measures, a much needed improvement in this field of administration can be effected.



## CHAPTER III.

### MEDICAL RELIEF AND PREVENTIVE HEALTH WORK IN THE PROVINCES

1. Having considered briefly in the previous chapter the administrative organisations for medical relief and preventive health work in the provinces, we shall describe here, in some detail, the existing facilities in these two fields of health administration. We shall deal with medical relief first.

#### Medical Relief

2. In the three provinces of Madras, Bombay and Bengal the administrative officer in charge of the medical department is known as the Surgeon General, while in other provinces the corresponding officer is the Inspector General of Civil Hospitals. The officer responsible for medical administration in a district is the civil surgeon. He is in charge of the district headquarters hospital, is the inspecting officer for all other public hospitals and dispensaries in the district and is, in certain provinces, responsible for public health administration also. In addition many calls are made on his time by his having to serve on various committees, official and voluntary, which are interested in health problems. A district is divided into sub-divisions which are normally in the medical charge of an officer of the provincial medical service, who holds a medical degree. He administers the sub-divisional hospital and looks after dispensaries in his own area. The hospitals and dispensaries in a sub-division are usually under the control of Government or of local bodies. The medical officers in charge of these are generally provincial service men with the qualification of licentiates.

3. In order to indicate the extent of medical relief available to the people we propose to give a series of tabular statements in which are shown the number of registered medical practitioners and of medical institutions as well as the staff and bed strength of the latter in individual provinces. We shall first deal with registered practitioners in the provinces.

#### Medical Practitioners (1941-42)

Provinces	Doctors registered			Ratio of registered medical practitioners to population
	Graduates	Licentiates	Total	
Assam . . . . .	194	1,185	1,359	1 to 7,509
Bengal . . . . .	4,586	7,690	12,276	1 to 4,913
Bihar . . . . .	991	2,262	3,253	1 to 11,171
Bombay . . . . .	4,430	4,971	9,401	1 to 2,218
Central Provinces and Berar . . . . .	279	874	1,153	1 to 14,582
Delhi . . . . .	174	82	256	1 to 3,586
Madras . . . . .	2,974	5,056	8,030	1 to 6,145
North-West Frontier Province . . . . .	121	161	282	1 to 10,773
Orissa . . . . .	129	535	664	1 to 13,145
Punjab . . . . .	1,994	4,330	6,324	1 to 4,494
Sind . . . . .	155	323	478	1 to 9,487
United Provinces . . . . .	1,627	2,421	4,048	1 to 13,586
TOTAL . . . . .	17,634	29,870	47,524	1 to 6,300

4. Taking the population of British India as 300 millions, the proportion of doctors to population (considering graduates and licentiates together) is approximately 1:6,300. In England and the United States of America the corresponding proportions are 1:1,000 and 1:750 respectively. We feel that, in comparing such ratios, great caution should be exercised because a number of factors must be taken into consideration in determining the optimum proportion of doctors to the population. Such factors include the incidence of morbidity in the community; the type of medical relief which the people desire, for instance, whether it should be a general practitioner service catering to their needs or a State organisation offering comprehensive diagnostic and treatment facilities to all; the nature of population distribution in the country, *viz.*, whether it be concentrated in a relatively small number of places or distributed widely over the country as a whole, and various other matters. A mechanical application of existing ratios in other countries to India is not therefore justified. Nevertheless, it seems fairly reasonable to conclude that the existing proportion in India, of doctors to population will have to be raised considerably if the standard of facilities for medical relief is to be made to approach the levels already attained in England and in the United States.

5. Turning to individual provinces the figures are not in themselves sufficient to show the true position with regard to the availability of medical attention. On the face of it one doctor to 2,218 persons in the province of Bombay may appear to be, by no means, an unreasonable figure. One to 4,494 in the Punjab or 1:4,913 in Bengal might be held to be, at any rate, better than 1:13,586 in the United Provinces and 1:14,582 in the Central Provinces and Berar. A correct picture of the situation will, however, be obtained only if the distribution of the available doctors in each province between rural and urban areas is also taken into consideration. The fact that the rural population is generally about eight or nine times as large as that of urban centres and that this population lives widely dispersed necessitates that the vast majority of the doctors should devote themselves to rural medical relief if the facilities available in both types of areas are to be reasonably similar. We have, unfortunately, been unable to obtain the necessary figures for every province in order to compare the distribution of doctors between rural and urban areas. In Bengal it is understood that the doctor to population ratio in urban centres is about three and a half times that in rural areas. In Sind the corresponding proportion between urban and rural areas is as high as 49:1. Taking these into consideration as well as the figures showing the distribution of medical officers working under official agencies in these two types of areas, we believe that it may not be far from the truth if the conclusion is reached that at least 70 or 75 per cent. of the total number of available doctors in the country must be practising in urban centres. If this estimate is even approximately correct, it will be seen that the medical care which the inhabitants of rural areas obtain from those who practise modern scientific medicine, is very much less than that which the urban population receives.

### Medical Institutions

6. In the following table the number of medical institutions in individual provinces is shown in relation to their respective populations:—

Provinces	Hospitals and Dispensaries			Average urban population served by one medical institution	Average rural population served by one medical institution
	Urban	Rural	Total		
(1)	(2)	(3)	(4)	(5)	(6)
Assam . . . . .	59	229	238	4,756	43,337
Bengal . . . . .	304	1,511	1,815	19,730	37,996
Bihar . . . . .	125	528	653	18,630	62,744
Bombay . . . . .	316	442	758	17,127	34,927
Central Provinces and Berar . . . . .	184	223	407	11,379	66,008
Delhi . . . . .	21	13	34	33,128	17,096
Madras . . . . .	276	972	1,248	28,496	42,672
North-West Frontier Province . . . . .	59	123	182	9,359	34,053
Orissa . . . . .	21	160	181	15,276	52,548
Punjab . . . . .	287	778	1,065	15,188	30,925
Sind . . . . .	73	154	227	12,215	23,658
United Provinces . . . . .	388	456	844	17,668	105,626

In every province the population to be served by a single medical institution is definitely more in rural than in urban areas. Another striking feature of the table is the disparity between the provinces regarding the ratio of institution to population in respect of both rural and urban areas. The number of medical institutions at present available is, in every province, far too small to provide a reasonable standard of medical service to the people, particularly in the rural areas. The lowest provision for the rural population is in the United Provinces. The average number of villages to be served in this province by a medical institution is 224. It seems fairly certain that an appreciable proportion of those living in rural areas may, throughout their lives, receive no medical aid from either a hospital or a dispensary.

7. Apart from the actual number of institutions we shall now consider the bed accommodation available in them to serve the needs of the people.

Provinces	Total number of beds	Ratio of bed to population	No. of beds to 1,000 of the population
Assam . . . . .	1,469	1 to 8,729	0.115
Bengal . . . . .	10,905	1 to 5,530	0.181
Bihar . . . . .	6,025	1 to 6,031	0.166
Bombay . . . . .	7,979	1 to 2,613	0.383
Central Provinces and Berar . . . . .	2,738	1 to 6,140	0.163
Delhi . . . . .	1,382	1 to 664	1.506



### CHAPTER III

Provinces	Total number of beds	Ratio of bed to population	No. of beds to 1,000 of the population
Madras . . . . .	14,776	1 to 3,339	0.299
North-West Frontier Province . . . . .	1,868	1 to 1,626	0.615
Orissa . . . . .	1,386	1 to 6,298	0.159
Punjab . . . . .	12,307	1 to 2,309	0.433
Sind . . . . .	2,057	1 to 2,205	0.454
United Provinces . . . . .	11,219	1 to 4,500	0.222

8. The above figures may be compared with the corresponding rates of bed strength in certain other countries, which are shown below:—

	Ratio of beds per 1,000 of population	Remarks (year)
United States . . . . .	10.48	(1942)
United Kingdom . . . . .	7.14	(1933)
France . . . . .	3.72	(1929)
Germany . . . . .	8.32	(1927)
U. S. S. R . . . . .	4.66	(1940)
British India . . . . .	0.24	

9. Apart from the inadequacy of the existing number of medical institutions and of the inpatient accommodation they provide to serve the needs of the people, their construction and equipment leave much to be desired. This remark applies to even some of the larger hospitals situated in the district headquarters towns and cities in the provinces. Reviewing medical institutions in Madras, which are generally situated in spacious compounds and are by no means designed entirely unsatisfactory, we discovered that, in two out of the five teaching institutions which we visited, there was no provision on the premises for the disinfection of infective bedding and clothing. In the Stanley Hospital, the Women and Children's Hospital and the Government Ophthalmic Hospital in Madras City, the outpatients departments do not approach modern requirements of even non-teaching hospitals and, indeed, their reconstruction on an extensive scale will be required. The laboratories in these hospitals are only clinical side-rooms. The existing conditions at the Irwin hospital in Delhi also call for adverse

comment. The design of the whole hospital is such as to increase the difficulties of the auxiliary medical staff in carrying out their duties, while the outpatient department is quite inadequate to meet the needs of a modern hospital. The Hindu Rao hospital, Delhi, is hopelessly out of date and, in our opinion, is so unsuitable for a medical institution as to require its early replacement by a more satisfactory building. In Bengal we may cite a typical Sadar hospital at Faridpur. At the time of our inspection, this hospital was clean and seemed to be well run with the limited staff available; the buildings, however, were old and in need of considerable repair. There was great overcrowding in the wards, accommodation for stores was inadequate and the high pressure steriliser needed immediate repair. Laboratory arrangements were practically non-existent. At Dacca the general impression produced after a visit to the Mitford Hospital was that it was reasonably satisfactory. Accommodation in the nurses' quarters was, however, wholly inadequate. The kitchen attached to these quarters was dark, was situated only ten yards from the dysentery and cholera ward and was not fly-proof. The facilities in the outpatients department were insufficient for treatment and teaching purposes. At Hyderabad (Sind) we noted in the Civil Hospital that there were no quarters for the nurses. Further, the nursing staff employed was deplorably short, there being but one sister and three nurses for 150 beds. The Sukkur Civil Hospital was not built as a hospital, it having been intended originally for police lines, and both equipment and accommodation were quite unsatisfactory. We do not propose to continue the story. We hope we have said enough to indicate that considerable capital expenditure will be needed in the provinces to improve the existing hospitals in the larger towns and in the headquarters of districts.

10. We may now turn to the dispensary, which should play an important part in the provision of medical relief to the rural population. Rural dispensaries too are, in many cases, functioning quite unsatisfactorily. The buildings, in which they are housed, are often inadequate to serve the purpose for which they are intended and their staff and equipment are also unsatisfactory. A single doctor, struggling with the help of a compounder, to deal with some hundreds of patients faces an almost impossible task. We noted, during our tours in the provinces, that the average time devoted to a dispensary patient may be as short as three-quarters to one minute. In such circumstances any reasonably correct diagnosis of the patient's condition would appear to be impossible. In most cases the supply of drugs and dressings is quite insufficient to meet the needs of the patients. Arrangements for patients to wait for their turn for examination require radical improvement, particularly in the case of women and children. The fact that the medical officers in charge of many of these dispensaries are often out of touch with modern medical practice, because they have had no opportunity of working in a well conducted hospital for many years, also helps to render the medical aid given by them to be of a low standard.

**Nursing Staff**

11. The position regarding the nursing staff is even worse. The number of nurses employed in public medical institutions in the different provinces is given below:—

Province	Nurses employed in medical institutions					
	Rural			Urban		
	European and Anglo-Indian	Indian	Total	European and Anglo-Indian	Indian	Total
Bengal . . . . .	13	29	42	392	536	928
Bihar . . . . .	17	26	43	97	196	293
Bombay . . . . .	2	42	44	211	957	1,168
Central Provinces and Berar . . . . .	4	25	29	31	177	208
Madras . . . . .	655					
North-West Frontier Province . . . . .	1	12	13	5	94	99
Orissa . . . . .	3	4	7	11	27	38
Sind . . . . .	103					
United Provinces . . . . .	257					
Assam . . . . .		48	48	14	..	14
Delhi . . . . .		..	..	104	200	304

The position in regard to nursing personnel indicated above is extremely unsatisfactory. Taking into consideration the fact that proper nursing is an essential part of modern medical practice, the numbers now employed in individual provinces reflect a state of affairs which will not be tolerated in any country in Europe or America. In those countries the optimum proportion of nurses to hospital beds is taken as 2.5:1. On this basis the total number employed in certain provinces is hardly sufficient to provide adequate nursing staff for even a single hospital of five hundred beds. Examples are Orissa, Sind and North-West Frontier Province. In the United Provinces with a population of over 50 millions, the total number of nurses employed is 257. If this country is to achieve, within a reasonable period, the nursing standards existing in other parts of the world, where health administration has advanced far more than in India, serious consideration will have to be given to the problem of producing and employing this class of auxiliary personnel on a much larger scale than has been attempted in the past.

**Special Hospitals**

12. We give below, in tabular form, the numbers of various types of special institutions in the provinces. The information is based partly on what has been supplied to us by the Director General, Indian Medical Service, and partly on what we obtained from provincial authorities in reply to a questionnaire which we circulated. We may also mention that, in addition to these institutions, there are in the country three special hospitals for children, two of them in Bombay and the third in Madras. While it is true that many hospitals, which provide medical care for women, also treat children, institutions devoting themselves entirely to the latter are, it is understood, limited to the three mentioned above.

*A list of special hospitals and other institutions.*

Serial No.	Province	Maternity and Child Welfare Centres		Eye Hospitals		Mental Institutions		Sanatoria		Tuberculosis				Leprosy Institutions		Infectious Diseases Hospitals		Venereal Diseases Hospitals	
		No.	Total Maternity beds	No.	Total beds	No.	Total beds	No.	Total beds	No.	Total beds	No.	Total beds	No.	Total beds	No.	Total beds	No.	Total beds
1	Assam	..	..	..	..	1	716	1	28	..	..	10	98	3	..	..	..	..	..
2	Bengal	87	821	1	139	2*	115	2	51	3	318	27	247	6	545	1	18	1	82
3	Bihar	21	362	..	..	2	1,651	1	130	..	..	10	97	8	2,178	1	36	..	..
4	Bombay	118	..	3	118	5	2,259	8	563	5	239	15	202	13	1,625	3	424 (for 2)	..	..
5	Central Provinces and Berar	83	323	..	..	1	600	1	151	..	..	7	91	9	2,202	2	28	..	..
6	Delhi	34†	..	1	74	..	..	..	..	1	96	1 (Clinic)	8	1	..	1	45	1 (Clinic)	..
7	Madras	..	..	1	170	3	1,416	5	513	1	52	17	400	12	2,902	3	210	..	..
8	North-West Frontier Province.	..	..	..	..	1†	140	1	144	..	..	6	152	..	..	..	..	..	..
9	Orissa	39	97	..	..	..	..	..	..	..	..	3	13	2	483	..	..	..	..
10	Punjab	206	345	..	..	1	1,408	9	654	3	163	14	348	6	871	..	..	..	..
11	Sind	5	..	2 hospitals and 2 mobile institutions	..	1	348	2	123	..	..	..	..	1	175	1	50	..	..
12	United Provinces	..	..	6	426	3	1,356	5	295	..	..	8	184	16	1,223	16	282	..	..

\* In Bengal, one is an institution to which mental cases are removed for observation and the other a private hospital with very limited accommodation.

† In N.W. F. P. (Peshawar). In addition there are two mental barracks in the Central Jail.

‡ Of these four are women's hospitals with a total bed strength of 697, of which 235 beds are for maternity and gynaecological cases.

13. In view of the wide prevalence in India of many of the special conditions of ill-health and disability included in the above-table, the hospital accommodation available in each case is quite insufficient to meet the requirements of the country. We may take three instances. The total number of beds available for tuberculosis patients is about 6,000 while estimates based on standards considered necessary elsewhere will place India's requirements at about half to one and a half million beds. A conservative estimate of the country's needs in respect of hospital accommodation for mental patients places the figure in the neighbourhood of 800,000 while the available number of beds (including the Indian States) is a little over 10,000. As regards eye hospitals the existing provision is less than 1,000 beds. The Blindness Committee appointed by the Central Advisory Boards of Health and Education has estimated that the existing number of the blind in India is approximately two millions. Lieut.-Colonel E. W. O.'G. Kirwan, I.M.S. (Retd.), a distinguished ophthalmologist with many years of experience in India, has estimated that "50 per cent. of the present blindness is curable". The Committee has pointed out that other workers in this field place the percentage of preventable and curable blindness at a substantially higher figure. In the circumstances the total inadequacy of existing provision for treating eye conditions becomes apparent. It will be seen that the difference between existing hospital accommodation and what the country requires is, in each case, enormous.

14. Infectious diseases hospitals also require special mention. Their number is very small and the conditions under which they are maintained are, generally speaking, quite unsatisfactory. From the information that we have been able to gather there are not even a thousand beds in the whole country for the treatment of cases of infectious diseases. This statement requires some qualification. Each of the infectious diseases hospitals is capable of being expanded considerably to deal with the demands of an epidemic. Such an arrangement is, in our view, the result of viewing the problem from a wrong angle for, in the absence of adequate facilities for the isolation of patients, an epidemic becomes almost inevitable. For some considerable time past, it has been the practice in the United Kingdom, the United States, France, Germany and other countries, for any town of a reasonable size, which maintains a general hospital, to provide a properly built, equipped and staffed infectious diseases hospital also on a permanent basis. The money spent on the latter is not considered a waste but a wise expenditure of public funds in the interests of the health of the community. The authorities in India must develop the same point of view if the incidence of infectious diseases is to be controlled effectively.

#### **State Aid and Voluntary Effort in the Provision of Medical Relief**

15. In the organisation of medical relief for the people voluntary agencies have played a large part in most countries. In India, on the other hand, the State has undertaken the major share in making such provision. The following tables gives the number of medical institutions (latest available) in the provinces classified according to the agencies responsible for maintaining them:—

# MEDICAL RELIEF AND PREVENTIVE HEALTH WORK IN THE PROVINCES

## Medical Institutions in the Provinces.

	STATE PUBLIC				STATE SPECIAL						Local and Municipal		Private aided from public funds		Private non-aided		Railways		Subsidised		Total		GRAND TOTAL
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	
Assam	26	13	12	15	..	..	6	..	155	22	3	3	7	2	9	4	11	..	220	59	298		
Bengal	12	13	1	29	..	..	7	6	1,201	139	111	26	130	56	42	35	7	..	1,511	304	1,815		
Bihar	14	11	1	14	2	..	..	..	307	60	15	3	52	17	24	16	53	4	528	125	653		
Bombay	5	33	1	3	..	..	2	4	127	182	6	16	13	45	12	33	276	..	442	316	758		
Central Provinces and Berar.	2	4	..	21	..	..	4	5	133	109	14	14	53	14	10	17	7	..	223	184	407		
Madras	78	98	3	5	1	..	13	..	330	99	46	19	48	30	26	25	377	..	972	276	1,248		
North-West Frontier Province.	52	4	5	12	2	..	38	4	19	20	1	1	5	13	..	5	1	..	124	59	182		
Orissa	38	6	..	4	..	1	1	..	96	7	4	2	6	..	7	1	8	..	160	21	181		
Punjab	1	63	..	32	69	4	14	11	570	106	11	25	4	6	1	40	108	..	778	287	1,065		
United Provinces	56	12	..	49	3	..	4	57	246	146	10	48	45	20	7	55	85	..	456	388*	844		
Sindh	1	8	..	..	..	..	1	..	71	48	19	9	1	13	2	10	..	..	95	98	183		
Delhi	..	5	..	1	..	..	..	..	7	18	..	6	†	†	..	2	..	..	7	32	39		

\* Includes one Government and one aided teaching institutions.

† Figures for Sind relate to the year 1937.

‡ Not known

It will be seen that, of the total number of 7,441 medical institutions in the provinces, only 566 or 7·6 per cent. are maintained wholly by private agencies. Of the remaining 6,875 institutions, 94·5 per cent. constitute entirely a charge on public funds (provincial and local body) while the remaining 5·5 per cent. receive grants-in-aid from such funds. The share that public revenues have borne in the provision of medical relief to the people is therefore very high.

16. This brief review of existing provision for medical relief in the country has made it clear that only a fraction of the requirements of the people is being met by the present services. Further, the quality of the medical aid made available to them is altogether of a low standard and it seems reasonable to hold that, from the point of view of effective relief to the patient, the return for the expenditure incurred (mainly by the State) is inadequate. When it is remembered that, in the past, the major effort in the field of health administration has been directed to the expansion of medical relief, the results achieved must be considered disappointing. We cannot help feeling that one of the causes responsible for this state of affairs has been the attempt to establish medical institutions without providing for their proper staffing, equipment and maintenance. The need is great for raising definitely the standard of medical service rendered by existing hospitals and dispensaries. It is equally necessary that the number of institutions should be increased considerably in order to bring them closer to the people and thus promote, in a growing measure, the application of modern scientific medicine to the improvement of the health of the country.

#### **Preventive Health Work in the Provinces**

17. We have already shown in the last chapter how the provision of whole-time public health staffs in rural and urban areas was actively promoted, in a number of provinces, by the new Ministries of Health which came into existence when the provisions of the Government of India Act of 1919 were brought into operation. The extent to which such services were provided was greater in some provinces than in others. The following tabular statement sets out the public health staff employed in the different provinces and Centrally Administered Areas. These figures were supplied by the Provincial Directors of Public Health in 1944:—





*The staff employed for preventive health work in rural and urban areas for the different provinces—contd.*

Provinces	Sanitary and Health Inspectors		Vaccinators				Midwives		Trained <i>dais</i>	
			Males		Females					
					Rural	Urban				
North-West Frontier Province	..	11	36	18	..	1	..	2	53	10
Punjab	67	185	370	160	..	5	†	†	†	†
United Provinces	223	208	762	195	..	..	160	199	54	80
Bihar	186	..	1,422	..	..	..	..	1	1	..
Orissa	56	15	303	10	5	2	2	4	10	16
Bengal	691	112	2,176	145	53	30	53	88	3,317	728
Central Provinces and Berar	..	83	286	94	..	..	..	104	76	608
Bombay	12	132	281	59	..	..	†	†	†	†
Sind	11	45	88	27	..	6	7	12	33	18
Madras	514	300	..	229*	679†	..	176	285	4	..
Assam	95	..	45	..	..	..	..	..	..	..
Delhi	8	29	22	18	17	..	8	1	17	39
Coorg	2	2	..	..	..	..	4	2	..	..
Baluchistan	4	5	7	1	..	..	..	2	..	6

\* Includes males and females.

† Includes males and females.

‡ No figures available.

18. In 1935 nearly half the districts and three quarters of the municipalities in British India had no qualified health officers. Between 1935 and the period to which the figures given above relate, the number of whole-time health officers, who are graduates in medicine and possess a public health qualification, increased only by 6 and the corresponding number of health officers who are licentiates increased by 18. For taking charge of rural health work in the districts and of urban health administration in the larger municipalities the health officer is generally required to possess a degree in medicine and a recognised public health qualification. Licentiates with special training in public health are generally appointed to the smaller municipalities. It will be seen that the progress made since 1935 in providing qualified whole-time health officers to rural and urban areas in the provinces has been very small. During the same period the number of sanitary or health inspectors employed in the country as a whole increased by 656, making a total of 2,976. We understand that a special Committee consisting of certain Directors of Public Health, the Directors of the Central Research Institute, Kasauli, the School of Tropical Medicine, Calcutta and the Pasteur Institute, Shillong, and some others, which discussed the problem of smallpox vaccination at New Delhi on 22nd November 1944, recommended that one qualified sanitary inspector should be appointed for every group of 25,000 people. Therefore, on the assumption that the population of British India is 300 millions, the number required is 12,000 as against the existing number of about 3,000.

19. The increase in the number of vaccinators during the same period was 925. A striking feature is that, as regards women vaccinators, the total increase in British India was exceedingly small. In 1935, only 45 women vaccinators were employed in the rural areas of the country and 37 in the urban areas. In the period intervening between 1935 and the year to which the figures in the above table refer (probably 1943 or 1944) the number of these women workers rose to 75 in the rural areas and to 44 in urban centres, a total increase of 37 for the country. In many parts of India it is only a woman vaccinator who can obtain access to the homes of the people and mix freely with the women. Therefore the extreme inadequacy of the existing numbers of women vaccinators available in the rural and urban areas of the country and of the rate at which their strength is augmented becomes emphasised.

20. Midwives and trained *dais*, who form an essential part of the special health services required for mothers and children, are also quite inadequate in numbers in all the provinces. We are discussing this matter as well as the extreme insufficiency of health visitors in that chapter of this volume which deals with services for mothers and children and shall not therefore go further into them here.

21. Apart from the inadequacy of staff indicated above, the quality of the preventive health service given to the people suffers considerably from the fact that the non-medical personnel discussed

in the preceding paragraphs lack adequate training and work under conditions which are not calculated to promote their efficiency. The deficiencies in existing standards of training have been discussed in the chapter relating to the survey of professional education. The conditions of service for these classes of health personnel vary considerably in the provinces, whether they be employed by Governments or by local bodies. We shall take sanitary or health inspectors first. In Bengal, the Central Provinces and North-West Frontier Province, Governments do not generally employ them while, in Bihar, it is understood that their services have been utilised by the Provincial Government only in connection with A.R.P. work at refugee camps and at aerodromes. The scales of pay offered to such inspectors varied from Rs. 30 to Rs. 40 a month. In other provinces the scales for inspectors in Government service range between Rs. 75 to 135 in Bombay and Rs. 40 to Rs. 80 in Orissa. As regards local bodies the variation is even higher, from a scale of Rs. 100 to Rs. 150 for district board sanitary inspectors in Bengal to Rs. 25 to Rs. 40 in certain local bodies in Orissa. The sanitary inspector is responsible for supervising the enforcement of the sanitary law in his area and an essential condition for efficiency is that he should be above temptation. The existing scales of pay in certain provinces are so low that no suitably qualified man can be expected to serve contentedly on such emoluments. The continuance of such rates of pay can only lead to inefficiency or corruption or both.

22. The position in regard to vaccinators is even worse. The range of variation in salary is from Rs. 10 in Bengal to Rs. 50 for a first class vaccinator in Madras. In the majority of the provinces the scale of pay is low. In Bihar and Orissa the conditions of service are most unsatisfactory. In the former vaccinators, who are paid from public funds, are employed only in municipalities. In rural areas they are normally engaged for duty only for the vaccination season (October to March), although they may also be called upon to work during an emergency. The fees realised for vaccinations carried out in the homes of the people form their sole remuneration. These vaccinators are given no travelling allowance.

23. In the rural areas of Orissa vaccinators work under a system of licence granted by the Provincial health authority. He is permitted to charge As. 2 for each successful vaccination and a fee of As. 4 for more than one successful vaccination in the same family, provided the operation is performed in the homes of the people. Vaccinators are required to perform all vaccinations, free of charge, if carried out in public places. Such low rates of remuneration and absence of security of tenure must make efficient service impossible. Vaccinators working in rural areas must be performing these duties under strenuous conditions and the withholding of travelling allowance from them can hardly be expected to promote efficiency. One of the reasons why vaccination against smallpox has not produced in this country such marked decline

in the incidence of the disease as has been demonstrated to be possible elsewhere is that the campaign has not been conducted in a manner calculated to produce effective immunisation of the people. Conditions of service such as those described above are a positive impediment to a successful vaccination programme.

24. We may also draw attention to another matter affecting the efficiency of the existing public health staffs in the provinces. In certain provinces they are servants of the local bodies in which they work. In others Provincial Governments have undertaken the maintenance of cadres for certain classes of health officials on a provincial basis. The general experience is that provincialisation of the services helps to secure and retain better types of workers on the public health establishments than a system of separate organisations maintained by individual local authorities.

25. From this brief survey of preventive health services in the provinces it will be seen that the existing staffs are altogether too small to provide adequate service to the large populations entrusted to their charge. Even in those provinces in which the preventive health organisation has been best developed, the staff employed can be considered to constitute only a nucleus from which must be expanded the much larger army of workers required for providing efficient service to the people. The existing public health staffs are mainly engaged on measures for the control of epidemic diseases and they are unable to cope adequately even with such measures.

26. Before we conclude this survey of existing provision in the provinces for medical relief and preventive health work, reference should be made to such laboratory services as are available for the medical and public health departments. For the proper diagnosis and treatment of disease laboratory facilities are essential while, in the field of preventive health work, food, water and sewage analyses and a diagnostic service in connection with the campaign against communicable diseases represent some of the important functions which the laboratory should perform. In addition, research into the varying problems of ill-health in the community, which arise from time to time, also constitutes a valuable contribution which the laboratory should make if sound health administration is to be carried on. In the provinces of Madras and Bombay the King Institute, Guindy, and the Haffkine Institute respectively are well equipped to carry out all these duties. The laboratory organisations in the Punjab and in the United Provinces, although they are not up to the standards of the institutions in Bombay and Madras, are adequate to fulfil the requirements of the respective public health departments. In other provinces the laboratory facilities that are available are of a lower standard and they vary to some extent from province to province. We have described, in some detail, the existing laboratories in the different provinces in the chapter dealing with the review of medical research in this volume of the report and do not therefore propose to go into further details here.

## CHAPTER IV.

### **THERAPEUTIC SUBSTANCES AND MEDICAL APPLIANCES, THEIR AVAILABILITY AND CONTROL OF THE TRADE IN THEM**

#### **Introduction**

1. We have found considerable difficulty in reviewing this important subject. There was, till recently, no specific enactment of the Indian Legislature which aims directly at the prevention of adulteration of drugs or which ensures conformity to proper standards of purity and strength in their manufacture. There are indirect provisions contained in the Indian Sale of Goods Act, 1930 (Section 15); the Sea Customs Act, 1898 (Sections 3, 6, 7, 9 and 17) and the Indian Penal Code (Sections 274, 275, 276 and 475). Further, legal control is to be found in the Cantonments Act, 1924, which empowers the Cantonment Authority to deal with "any article of food or drug" which is adulterated or different from that which it is represented to be within the Cantonment areas. In the Poisons Act, 1919 and the Opium Act, 1878, and the Dangerous Drugs Act, 1930, attempts have been made to control, to some extent, the manufacture, importation and sale of certain drugs, but the provisions laid down in these various Acts have no immediate bearing on the subject of adulteration or the standards of strength or purity of drugs in general. This position has been rectified by the passing of the Drugs Act, 1940, referred to in the succeeding paragraph.

#### **The Drugs Act, 1940**

2. In 1930 the Government of India appointed the Drugs Enquiry Committee under Sir Ram Nath Chopra to investigate the drug position in India. In 1940 the Drugs Act was passed by the Central Legislature giving statutory sanction to the recommendations of that Committee regarding drug control. This Act provides for the control of drugs imported into India as well as of their manufacture, sale and distribution in the country. The Central Government is responsible for the control of import, while the Provincial Governments are authorised to regulate the manufacture, sale and distribution of drugs inside their respective territories. In order to carry out these purposes the Act provides that the Central Government shall, as soon as may be, constitute a Board to be called the Drugs Technical Advisory Board as well as a Central Drugs Laboratory. The Drugs Technical Advisory Board, which has already been appointed, is responsible for advising the Central and Provincial Governments on technical matters connected with the administration of this Act. It has had several sittings and has advised the Government of India on the compilation of the Drugs Rules under the Act. These Rules were published for criticism in April, 1944, and it is understood that, after such criticism was fully considered by the Drugs Technical Advisory Board and the Central Government, the draft Rules are now in their final form for publication at an early date. It is believed that the Drugs Act and the Rules under it will come into force early in 1946.

3. The Central Drugs Laboratory has not yet been established. Its function will be to carry out the analysis of samples of imported drugs and biological products sent to it from the ports as well as of samples of drugs submitted from the provinces to be analysed for a second opinion. This laboratory will also be responsible for the grant of certificates of registration in respect of imported patent or proprietary medicines with undisclosed formulae. The Government of India established, about ten years ago, a Biochemical Standardisation Laboratory for the purpose of working out details regarding biochemical estimations, when carried out under tropical conditions. This laboratory can suitably constitute the nucleus organisation from which the Central Drugs Laboratory required under the Act may be developed. During the war, the Military Authorities and the Supply Department used extensively the Biochemical Standardisation Laboratory for testing drugs and, in this way, it has developed a wide range of experience in the testing of these substances.

4. The Central Government is also authorised, under the Act, to constitute an advisory committee to be called the Drugs Consultative Committee to "advise the Central Government, the Provincial Governments and the Drugs Technical Advisory Board on any matter tending to secure uniformity throughout the provinces in the administration of this Act". This Committee will consist of two representatives nominated by the Central Government and one representative nominated by each Provincial Government. It has not yet been established.

5. As has already been pointed out, the control of the manufacture, sale and distribution of drugs within their own territories is the function of Provincial Governments. In order to carry out these duties the Act provides for the appointment of Analysts and of Inspectors by these Governments. The provincial Analyst will normally be responsible for the analysis and certification of samples of drugs taken by the Inspectors but, in cases of dispute, a second opinion can be obtained from the Central Drugs Laboratory either by the court or by any of the parties involved in the prosecution of a case.

6. The control of the therapeutic substances commonly known as vaccines and sera will also be carried out under the Drugs Rules and the Drugs Act. The control of the manufacture, import and sale of these substances is on very similar lines to those of the Therapeutic Substances Act, 1925, of the United Kingdom. During the War a large number of firms have set up business in the manufacture of sterilised products such as vaccines and sera. We recognise that some of the leading commercial firms in India have already made great strides towards the production of biological products under much more satisfactory conditions than was formerly the case, but the need exists for the continuous supervision of their preparations.

#### **Drugs and Medical Appliances Manufactured from Indigenous Material**

7. We propose to refer to a few important drugs manufactured from raw material found in India, the production of which has received a stimulus on account of the War.

*Morphine*.—This drug is derived from opium, the manufacture of which is controlled by the Central Board of Revenue. The production of morphine has been immensely stepped up and improved and there seems to be little reason why India should not be able to meet her entire demand herself.

*Codeine*.—The local manufacture of this drug has also been considerably increased recently and India is now in a position to meet her normal civil requirements and even to export a small surplus in peace time.

*Strychnine*.—Local production has greatly increased and a large export trade, especially to Australia, has been built up.

*Caffeine*.—India is now a very large producer of Caffeine as it was in the last war, but the industry did not survive post-war (1914-18) competition.

*Santonine*.—Sufficient is now produced to satisfy India's requirements and to export a surplus.

*Quinine*.—We have referred to this in the section dealing with malaria, with the suggestion that, for any future planning, the question of the cultivation of cinchona and the production of quinine on a much larger scale than anything that has yet been attempted, should be given a prominent place.

*Pyrethrum*.—Experiment in the growing of this useful plant has demonstrated that there are many areas in India where it can be grown and where its flowers produce a reasonable pyrethrin content. The Government of India purchased 236,000 lbs. of Indian grown pyrethrum during the period from 1st June 1944 to the end of May 1945. This represents probably the bulk of the pyrethrum grown in India at the present time.

*Ipecacuanha*.—It is now thought that, if proper attention is paid to the growing of this root in India, we should be able not only to supply our own needs but also to produce a surplus to export.

- We have selected at random some of the more important drugs, our purpose being to indicate that there lies a considerable future before the drug manufacturing industry in India. We should emphasise, however, the necessity for the institution, as early as possible, of effective control over the production of drugs, if the trade is to be developed. Little effort has yet been made in India to recover valuable chemicals from coal tar which form the basis of many synthetic drugs. A certain amount of Carbohc Acid, Benzene and Toluene is recovered in India at present from coal tar. Much larger quantities of these products are, however, lost because the producing interests concerned find it suits them better to manufacture tar for use on roads.

Medical appliances such as surgical dressings, Plaster of Paris, artificial limbs and dental cotton are now produced in India in large quantities. The surgical instruments industry has also developed enormously but is still dependent on many imported raw materials for its work.

**Pharmacy Legislation**

8. The Drugs Act and the Rules under it should be supplemented by legislation to regulate the practice of pharmacy. We understand that this is being provided for by a Pharmacy Act which will be brought before the Indian Legislature shortly. This Pharmacy Act will, we believe, establish a Central Council of Pharmacy to regulate the education of pharmacists and the standard of examinations to be passed by qualified pharmacists. The Act will also, it is understood, arrange for the establishment of Provincial Councils of Pharmacy to maintain registers of qualified pharmacists and to regulate the professional conduct of pharmacists.

**Manufacture of Scientific Glassware**

9. An important industry in connection with the supply of medical equipment is that connected with the manufacture of glassware. There exists a sufficient supply of the necessary raw material in the country with a long tradition in the manufacture of glass articles of a simple nature. We are informed that, at the outbreak of the War, no scientific glassware was being produced in India and that no laboratory equipment was being made of neutral glass. This position has been changed and neutral glass, which is necessary to store certain medicines and biological products, has been and is being produced in this country.





## CHAPTER V

### THE NUTRITION OF THE PEOPLE

#### Nutrition

1. A population which is habitually used to a diet which is sufficient in both quality and quantity will have a store of general health and vitality, which will enable it both to resist the onset of disease and successfully to combat it, when it arises. On the other hand, faulty nutrition is directly and indirectly responsible for a large amount of ill-health in the community. A continued insufficiency of specific food factors in the diet is associated with special conditions known as deficiency diseases. These include beri-beri, which is fairly common among adults and infants in the Northern Circars of Madras Presidency, keratomalacia a common cause of permanent blindness in South India, osteomalacia and rickets in certain parts of North India, and goitre in some areas in the Himalayan and Sub-Himalayan regions.

#### Estimates of Food Production

2. It is very difficult to obtain accurate information in regard to food production in the country. Statistics of various crops and their total areas are published annually by Provincial Governments and are tabulated at the Centre. Little reliance can be placed, however, on these. For example in some provinces, *e.g.*, Bengal, Bihar, Assam and Orissa, the area under the different food crops cannot be accurately estimated. Production figures are available for only 56 per cent. of the Indian States' territory, yet the latter comprises 45·3 per cent. of the total area of India and contains 24 per cent. of the country's population. In the absence of accurate statistics with regard to food production, it is only possible to make a conjectured estimate of the overall position. The bulk of a typical Indian diet is composed of cereals and it is, therefore, with the production figures of these that we are primarily concerned. The Food Grains Policy Committee (1943) considered that a reasonable estimate of the total annual production of cereals in India is 50 to 55 million tons. From this total quantity a deduction, the amount of which cannot be assessed, should be made for the grain fed to live-stock. The next step is to correlate this total estimated production with the needs of the community. For a population for which one or other of the cereals represents the basic food, nutrition experts have suggested that 1 lb. per head per day may be taken to represent the reasonable requirements of the individual. Taking the population of the whole of India as approximately 400 millions, at least 65 million tons of cereals will be required annually for human consumption. It is clear that the production of cereals in India falls short of the country's reasonable requirements.

Cereals, *i.e.*, mainly rice and wheat are, however, only part of a satisfactory diet which should include adequate quantities of other foods such as milk, pulses, vegetables, fruit, meat, fish and eggs.

*Milk.*—Taking milk and dairy produce in general and again emphasising the fact that it is possible to make only very rough estimates of total production, we believe that the probable figure

for the total annual production of milk is about 22 million tons.\* If from this we deduct about 15 per cent. for the needs of calves there is left, in terms of fresh milk, a possible daily *per capita* intake of about 5 ozs. It must, however, be appreciated that the production of milk varies very considerably in different parts of India. It approximates to 19·7 ozs. per head of population in the Punjab and 3·6 ozs. in Madras Presidency and we believe that, in India as a whole, the diet of the poorer classes includes milk, if at all, only in negligible quantities.

*Pulses.*—Pulses are grown throughout India and are consumed by all classes in the country. They are, as a matter of fact, essential to agriculture since, in the absence of the cultivation of leguminous crops in rotation, the fertility of the soil cannot be maintained. The estimated total annual yield of pulses is some 7 to 9 million tons which, on a *per capita* basis, provides less than 3 ozs. a day. This is again much below the desirable limit.

*Vegetables and Fruits.*—Such information as is available would seem to show that vegetables are grown in altogether insufficient quantities. Further, we believe that an unsatisfactory feature is that fruits and vegetables of the less nutritious varieties are often produced in preference to those of higher nutritive value.

*Eggs, Meat and Fish.*—Eggs are consumed in quite negligible quantities by the poorer classes in both villages and towns and are frequently excluded from the dietary on account of religious objections. The total production of eggs is believed to be small in relation to the daily *per capita* requirement. The live-stock of India is considerable and, probably, in many areas there are actually too many cattle. Meat, however, forms a very small part of the diet of the greater section of the population. Here again social custom plays a part but, in many cases, price is a decisive factor.

*Fish* is a source of food which as yet is undeveloped, although it is understood that some expansion of this industry has taken place within recent years. The average annual production is about 660,000 tons, the bulk of which is sea fish. We understand that the Government of India and Provincial Governments are attempting to increase fish production, popularise the use of this most nutritious food and provide the necessary facilities for its distribution.

*Sugar.*—This article of food is produced in very large quantities in India, which indeed produces more sugar than most other countries in the world. The total production of sugar, refined and unrefined, is estimated at 5·3 million tons which amounts to approximately 1·3 oz. *per capita* daily. This, however, is a quantity considerably below what is consumed in normal times in Great Britain and the United States of America.

The only important article of food imported into India before the war was rice from Burma and, to a smaller extent, from Siam

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\* The production figures for different articles of food are quoted from the pamphlet on nutrition in the Oxford Pamphlet Series, by Dr W. R. Aykroyd (May 1944).

and Indo-China. In normal times, the total amount imported was some 4 to 5 per cent. of India's rice supply. The import of other foodgrains was negligible.

This brief review of food production is, we consider, sufficient to warrant the statement that the total food supply is insufficient in quantity and that the diet of the population as a whole is defective in quality, since the protective foods which are needed to supplement the basic cereal grains are not produced in anything like adequate quantities.

### Storage and Distribution of Food

3. In order to ensure the satisfactory nutrition of the people, food production on a scale sufficient to meet the country's requirements should be linked with measures which will help to enable all sections of the population to obtain a balanced diet. Provision for the proper storage and distribution of food constitutes an important part of such measures. We are satisfied that a very great deal needs to be done in these directions throughout the country as a whole. The provision for the rapid and efficient transportation of perishable foods from one part of the country to another is extremely inadequate and this remark applies particularly to fruit and fish. We shall refer specifically to the question of the production and distribution of milk later. We recognise that the distribution of food is a very complicated matter, involving as it does problems of transport and marketing. These factors have an intimate bearing on the price of food, which ultimately determines the level of nutrition in the community.

### The Economic Aspect of the Problem

4. The Nutrition Research Laboratories at Coonoor have suggested that the following additions to one pound of cereals will constitute a sufficient and well-balanced diet for an ordinary adult per day:—

	oz.
Milk . . . . .	8
Pulses . . . . .	3
Non-leafy vegetables . . . . .	6
Green-leafy vegetables . . . . .	2-4
Fruits . . . . .	2
Fats, oils . . . . .	2

The cost of a diet such as that described above would vary between Rs. 4 and Rs. 6 a month in pre-war days. Taking an average family as containing the equivalent of four adult persons, the cost of food for such a family would vary between Rs. 16 and Rs. 24 a month. These figures give a striking illustration of the gulf that existed between the expenditure necessary on food and that which large numbers of workers could afford, having regard to their wages. A peon in the Government of India Secretariat was paid as little as Rs. 15 per month in the pre-war period. In spite of allowances to meet the increased cost of living there is no reason to believe that the gulf has in any way been narrowed.

5. Attempts have been made to study the relation between income and diet in various parts of India, chiefly in industrial areas, from which it has been deduced that there is normally a rise in the consumption of non-cereal foods, *e.g.*, milk, vegetables and fruit, with an increase in income. This means that in this country, as elsewhere, an increase in income generally leads to improvement in the diet in the right direction.

6. Diet surveys carried out in different parts of the country have shown, in typical urban and rural groups, that the food consumed is insufficient to provide the necessary energy requirements in the case of some 30 per cent. of the families, that the diet is almost invariably ill-balanced and that there is, in terms of food factors, a deficiency in fats, vitamins, and proteins of high biological value. The insufficiency of these essential food factors in the diet of large sections of the people is, no doubt, a contributory factor to the high incidence of morbidity and mortality in the country. Infants and expectant and nursing mothers particularly require such important elements in their food and the malnutrition resulting from the absence or inadequacy of these in their diet is responsible, in part, for the high rates of infantile and maternal mortality. There is also a close association between the prevalence of tuberculosis and defective diet.

#### **Nutrition Work in India**

7. While the basic problems relating to food production and distribution remain to be tackled, it may be mentioned that, within recent years, some advance has been made in defining the extent and nature of the nutrition problem in India through diet surveys and through research into various aspects of the subject. In addition, a beginning has been made in the training of health workers in the field of nutrition. Much of this work has been carried out under the auspices of the Indian Research Fund Association, which is almost entirely financed by the Central Government. This Association maintains the Nutrition Research Laboratories at Coonoor, which have taken a prominent part in the activities mentioned above. The Nutrition Advisory Committee appointed by the Association, which consists of leading nutrition workers in the country, Central and Provincial Health Department Officers and representatives of the Agricultural and Animal Husbandry Departments, is performing valuable work by directing nutrition research carried out in different parts of the country under the auspices of the Association and by discussing national nutrition problems from the technical point of view. The recommendations of the Committee are communicated to Provincial Governments through the Government of India.

8. The diet surveys have helped to provide the outlines of a picture presenting the dietetic habits and nutritional status of the people and, howsoever incomplete in details this picture may be, it has served the valuable purpose of stimulating public interest and of providing material on which administrative action can be initiated for a comprehensive policy directed to the raising of the standard of nutrition in the community. The promotion of active research

by the Indian Research Fund Association in nutrition problems, in various centres in India, including the universities, has helped to produce a body of keen and capable nutrition research workers, who are bound to play an important part in the campaign for raising the general standard of nutrition. Such research has been correlated to some extent, though perhaps not as much as it should be, with similar activities carried on by agricultural and veterinary officers through facilities afforded by the Imperial Council of Agricultural Research. The results have been made available to administrations and others interested in this problem, through reports of the Nutrition Advisory Committee of the Indian Research Fund Association and through Bulletins published by the Nutrition Research Laboratories at Coonoor and by the Imperial Council of Agricultural Research and other institutions. A scheme of training for nutrition officers was inaugurated in 1937 at the Nutrition Research Laboratories, Coonoor, and, up to date, the Governments of Bengal, Bihar, Madras, Bombay, the Punjab, Hyderabad (Deccan) and Baroda have appointed special Nutrition Officers. Thus the ground is being prepared for a continuous study of the nutrition problems of the country and for the practical application of the knowledge in the subject, which the country already possesses. But this, in our view, is no more than a beginning. Speaking generally, comparatively little has been done by Provincial Governments in this field and the responsibility rests on them to place in the forefront of their reconstruction programmes, measures for dealing with this problem, the solution of which is fundamental to the welfare and progress of the people.

9. We have refrained from making a reference to the activities of the Food Department of the Government of India because we have, as has already been pointed out, confined our review of this and other subjects relating to the public health of the country to the period ending with the year 1941.

#### **Supervision of Food Supplies to ensure the Maintenance of Health Standards**

10. We shall consider here the action taken by health authorities for the control of food adulteration as well as for the supervision of the production and sale of various articles of food for public consumption.

11. *Control of food adulteration.*—The responsibility for controlling food adulteration rests on Provincial Governments. In all provinces the necessary powers have been provided by Provincial Food Adulteration Acts. These Acts entrust the enforcement of the law against adulteration to local authorities and give considerable powers of supervision and control to Provincial Governments. Each Government is empowered to apply the Act concerned either to the whole area under its charge or to particular local areas as well as to apply it to all or to specific articles of food. In the two provinces of Bihar and the United Provinces the Act

concerned provides for the control of adulteration of drugs in addition to that of food.

12. Adulteration of different articles of food is widely practised in the country. In 1940, of the total number of samples examined in each province, the highest percentage of adulteration was recorded in the Central Provinces (84·9 per cent.)\* and the lowest in Sind (19·9 per cent.). An inter-provincial comparison based on such figures is not, however, justified because the extent of territory over which the Food Adulteration Act has been made applicable in the different provinces varies considerably as well as the vigour with which it is enforced. For instance, the Food Adulteration Committee of the Central Advisory Board of Health stated in its report that it "formed the opinion that, in large areas in which the Act is said to be in operation in certain provinces, its working can exist only on paper". The Committee has drawn attention to the fact that the methods of analysis employed in the provinces have not been standardised and this may also explain, in part, the divergence between the percentages for individual provinces.

13. The chief articles of food which are found adulterated are milk and milk products and the edible oils. The percentage of adulterated samples in respect of milk and milk products varied, in 1937, from 100 per cent. in the case of the Central Provinces and Delhi to 15·9 per cent. in the case of Sind. Samples of edible oils showed percentages of adulteration ranging from 80·0 per cent. in Bengal to 5·4 per cent. in Assam.

14. The defects in the enforcement of the food adulteration law in the provinces include the following:—

- (1) In certain provinces the operation of the Act has been extended to specific areas, without due regard being given to the need for ensuring that the local authorities concerned possess adequate funds and personnel to enforce the Act.
- (2) In many areas local authorities have availed themselves only to a very limited extent, or not at all, of the existing facilities for taking samples and getting them examined. The Food Adulteration Committee has pointed out that "in the Punjab, the United Provinces and Baroda there are instances of local bodies failing to send even a single sample for examination during 1940, while in certain other provinces the number of samples from individual local bodies is as low as one or two for the whole year".
- (3) Failure to prosecute offenders under the Act is to be found to a varying extent in the different provinces. The power to sanction prosecution is vested in the executive authority of the local body concerned. As has been

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\* These and other figures relating to food adulteration are quoted from Parts I and II of the Report of the Food Adulteration Committee of the Central Advisory Board of Health (1939 and 1943).

pointed out in the second chapter of this volume of our report, the Chairman of the local body, who is the executive authority in most parts of the country, often finds it difficult to enforce the law in the face of opposition from vested interests, probably because he lacks the support of a strong public opinion for such enforcement in the interests of the community. Instances have been quoted, by the Food Adulteration Committee, of local bodies having instituted no prosecutions at all and of others in whose case only six per cent. or less of the total number of offenders under the Act were prosecuted.

In this connection it may be mentioned that, in the province of Madras, all the executive powers under the Food Adulteration Act were transferred, under the provisions of the Madras Public Health Act, 1939, to local health officers. Further, the Provincial Government has issued instructions that every case of adulteration should be prosecuted. It is understood that, in this province, the vendors of all samples certified by the public analyst as adulterated are invariably prosecuted, except where accidental adulteration is suspected. In such cases the vendor is warned and another sample taken at a later date.

- (4) The fines imposed by the courts are, in many cases, so light that they have no deterrent effect on the offenders. Imprisonment, if it can be awarded for repeated offences under the Act, will have a salutary effect. In certain provinces, however, there exists no provision for imprisonment for offences under the Act.
- (5) Delays in the disposal by courts of cases under the Act, sometimes as long as a year and a half, are said to have hampered the working of the Act in certain provinces.

15. *Control of the production and sale of food to the public.*—The provincial Local Self-Government Acts contain provisions enabling the local authority to control, from the hygienic point of view, the production and distribution of food and articles of drink such as aerated waters, when they are meant for human consumption. Such control extends to markets, slaughter houses, bakeries, sweetmeat shops and eating establishments, dairies and the collection, transport and distribution of milk and milk products and the sale of meat, fish and other articles of diet. No person can establish a market or a slaughter house or carry on the other trades mentioned above in the area of a local authority without obtaining a license from it. In granting the license, that authority can lay down such conditions as it deems necessary to ensure the effective observance of health standards. At least in certain provinces local bodies also possess the power to seize and destroy articles of food unfit for human consumption if they are perishable and, if not, to do so under the orders of a magistrate.

16. It may, however, be mentioned that, in respect of the vast majority of local authorities, the control exercised is so unsatisfactory that the conditions under which food production and sale to the public are taking place constitute a grave menace to the health of the people. In many cases, the sanitary conditions of markets and slaughter houses maintained by the local bodies themselves fall far below minimum standards of hygienic requirements.



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## CHAPTER VI

### HEALTH SERVICES FOR MOTHERS AND CHILDREN

#### The extent of Morbidity and Mortality among Mothers and Children

1. The importance of the health problems of mothers and children become emphasised from a consideration of the following facts. Nearly one-half of the total deaths at all ages in British India takes place among children under 10 years. Of these nearly a half is among infants under one year. A conservative estimate of the annual number of deaths among women in the reproductive ages from causes associated with pregnancy and childbearing is 200,000 while the number of women who have to undergo, each year, varying degrees of disability and suffering from the same causes is likely to be about four millions if the ratio of maternal morbidity to mortality considered reasonable elsewhere can be applied to India.

2. Some idea of the relative effect of the causes associated with pregnancy and childbearing in raising the mortality rate of women in this country as compared with that of England and Wales may be obtained from the figures given below:—

—	Period.	Sex.	0-1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49
British India,	1930-32	M	184.4	37.6	10.0	6.3	8.9	9.5	..	12.6		18.7	
		F	167.1	34.6	9.9	6.3	10.6	11.9	..	13.3		16.3	
England and Wales,	1930-32	M	72.2	7.5	2.3	1.5	2.5	3.3	3.3	3.6	4.8	6.4	9.3
		F	54.9	6.8	2.0	1.4	2.3	2.8	3.1	3.3	3.9	4.9	6.7

In England and Wales female death rates are lower than those for males at practically all the age periods, although there is a noticeable lessening of the difference between the two rates during the years that constitute the reproductive period for women. This is due to the added risk of death which childbearing brings to women during those years. On the other hand, in India, this risk is presumably greater than in England and Wales because the female death rates during 15-40 are distinctly higher than the corresponding rates for men although, at the earlier and later age periods, these rates are, as in the case of England, lower than those for males.

3. The high rates of sickness and mortality among children must result, apart from the large amount of preventible suffering and economic loss it produces, in the survival of a proportion of them with varying degrees of damage to their physical and mental powers, so that the contribution which they may normally be expected to make to the general welfare of the community will naturally become reduced. The prevailing high rates of maternal morbidity and mortality are also bound to exert an adverse influence on the health and happiness of the children and other members of the affected homes. When it is remembered that, in certain countries, the rate of infant mortality

is only about a third to a fifth of that of India and that the maternal death rate has been brought down to about 3 to 4 per 1,000 births as against India's estimated rate of 20 per 1,000, it becomes possible to obtain some idea of the extent of damage that preventable causes produce among mothers and children in this country.

#### **Measures necessary for the Protection of Motherhood and Child Life**

4. "The health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities and upon the facilities for exercise and leisure." We shall not consider the problem here in this wider aspect but shall confine ourselves to the question of essential services to protect the health of mothers and children. These services should provide for the antenatal supervision of expectant mothers, for skilled assistance at childbirth, including institutional facilities where necessary, for the postnatal care of mothers and for adequate health protection to children from birth through the successive stages of infancy and early and later periods of child life. From the general description we have already given, in Chapter III of this volume of the report, of the existing health organisation in the provinces, preventive and curative, it will be seen that the provision is altogether inadequate to meet the needs of the community as a whole. In the field of maternity and child welfare the position is no better and is perhaps even worse. The development of special health services for mothers and children is relatively of more recent date than that of general medical provision for the community even in those countries in which health administration has advanced to a greater extent than in India. Here the growth of maternity and child welfare work has been, broadly speaking, mainly through voluntary effort and there is not, as yet, evidence of an adequate recognition by Governments of the need for an organised programme of development in this field.

#### **Development of the Maternity and Child Welfare Movement in India**

5. The movement started with attempts to train the indigenous *dai* for the practice of better standards of midwifery than those she had been accustomed to practise. The earliest attempt in this direction was made by Miss Hewlett of the Church of England Zenana Mission in 1866. In 1885 the Dufferin Fund Committee was established with the object of providing medical aid to the women of India through women doctors. This Fund, assisted by a small grant from the Government of India, opened the Lady Reading Health School in Delhi in 1918 for the training of health visitors. This was followed by the founding in 1919 of the Lady Chelmsford All-India League for maternity and child welfare. In 1930, under the auspices of the Indian Red Cross Society, a Maternity and Child Welfare Bureau was established for the purpose of promoting maternity and child welfare work throughout the country. The next step was the establishment in 1933 of a

training course in the All-India Institute of Hygiene and Public Health, Calcutta, which qualifies women doctors for a diploma in maternity and child welfare granted by the Faculty of Tropical Medicine and Hygiene, Bengal.

**Existing Numbers of Midwives, Health Visitors, Women Doctors and the Probable Numbers required**

6. *Midwives*.—The training of midwives preceded in India the training of nurses and it started with the establishment of hospitals about a century ago. There are now about 5,000 practising midwives in the country with approximately 300 qualifying themselves for the profession annually. For a total of probably ten million births each year in British India about 100,000 midwives will be required for providing adequate service to the people, on the basis of one midwife to 100 births. Lack of skilled service by qualified midwives plays an important part in the prevailing high rates of maternal mortality and of infantile deaths in the first month after birth (these form about 45 to 50 per cent. of the total infant mortality in a year). The need for making available, as quickly as possible, an increasing number of this class of trained workers for midwifery service, is therefore urgent. In view of the large difference between the existing number of midwives and that necessary to meet the requirements of the country as well as of the difficulty of producing rapidly fully trained midwives in adequate numbers, the question will have to be seriously considered whether, as an interim measure, the indigenous *dai* cannot be trained and made to work under proper supervision, so as to render her reasonably satisfactory for her duties.

7. *Health visitors*.—The total number of health visitors in the country is about 700 or 750. Since the establishment of the first training school in Delhi other institutions have been started in different parts of the country. There are now seven schools training some 60 pupils annually. It is considered that at least one health visitor will be required to supervise the work of five midwives, if her duties are confined to the supervision of midwifery practice. If the health visitor is to undertake other duties also, such as nursing the sick in the homes of the people (which is what a public health nurse is required to do in other countries) the number necessary for the country as a whole will be much more. Even with her duties restricted to the supervision of midwives about 20,000 health visitors will be required to control the work of 100,000 midwives.

8. *Women doctors*.—The number of women doctors in India, including graduates and licentiates, is not definitely known, but it is believed that their total strength will not exceed 4,000. Of these about a thousand are probably in public service, while another thousand are not, for various reasons, practising the profession. The remaining 2,000 are, it is believed, in general practice. The large majority of those who are in public service and in private practice are working in urban areas, particularly in the larger towns and cities. Even in these urban areas the number of medical women available is not sufficient to provide

adequate medical relief for women and children, while in rural areas the position is much worse. Turning to preventive health work for these sections of the population, which maternity and child welfare organisations are intended to provide, we find that the total number of women doctors with special training in this branch of health administration is only about a dozen medical graduates and about 50 or 60 licentiates. Another eight graduates are expected to complete such training by April 1946. The licentiates have had, generally speaking, only short courses in maternity and child welfare work, while the women graduates have had the full training for the diploma in the subject.

9. In most parts of the country maternity and child welfare centres are run by health visitors. Madras and Delhi are the only provinces in which women doctors are employed in this organisation in both urban and rural areas. In certain provinces even the supervision of this service, which is manned by health visitors, is carried out by medical women without any special training in maternity and child welfare work.

10. The proper development of antenatal, intra-natal and post-natal care of women will require the employment of women doctors in sufficient numbers in the maternity and child welfare organisation. In the circumstances described above it will be seen that the existing level of maternity and child welfare work in the country as a whole must be of a very low standard. Our proposals to expand this important service as part of the future health programme will necessitate the training of large numbers of women as doctors as well as their specialisation, later, in this branch of health work.

11. The present position as regards this health service may be broadly summarised as follows:—

- (a) Madras is the one province in which an effort has been made to organise maternity and child welfare work on systematic lines, although specially trained medical women devoting their whole time to the development of maternity and child welfare work exist in the provinces of Bengal, the United Provinces and Orissa. It is understood that, in the Punjab also, a woman doctor has recently been appointed on the staff of the Director of Public Health to promote the development of this activity in the province as a whole. This lady has not had, it is understood, any special training in maternity and child welfare work.

The following is the summary of the work carried out in 1942 in the province of Madras:—

Fourteen district boards and 32 municipalities maintained 225 centres, which employed 51 women medical officers, 32 health visitors and 422 midwives. The total expenditure was 3.31 lakhs. It should be mentioned that, although a much larger number of medical women are employed in this organisation

in Madras than in other provinces, they are mostly licentiates and have had only a short course of special training in the subject. 7,900 clinics were held, 53,100 deliveries were attended to by qualified midwives and a total of about a million home visits was paid by the different categories of workers together. It seems unnecessary to go into the details of maternity and child welfare work in other provinces when only about three per cent. of the total births could be reached by the organisation even in Madras, where the service has been best developed.

- (b) Dai training under the Victoria Memorial Scholarships scheme has generally proved unsatisfactory. Probably the chief reason is lack of supervision of their work after training.
- (c) The main defect in midwife training is the general absence of experience in domiciliary work.
- (d) The level of training in health visitors' schools is, with the exception of Lady Reading School, generally of a low standard, particularly in respect of practical training.
- (e) The general absence of either provincial or municipal organisations to which maternity and child welfare officers might be recruited has resulted in few candidates offering themselves for training for the diploma in maternity and child welfare. Such candidates as do take up the course are deficient in training in both preventive and clinical pediatrics and in preventive obstetrics.

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## CHAPTER VII

### HEALTH SERVICES FOR SCHOOL CHILDREN

1. The aims and objects of a school health service include the provision of adequate health protection to school children and the inculcation of the hygienic mode of life in them. A school health organisation should provide for:—

- (1) the maintenance of a high standard of environmental hygiene in schools;
- (2) adequate health protection to the children, based on periodical physical examinations, correction of defects and preventive work, including prophylactic inoculations, where necessary, and follow-up in the homes of the pupils;
- (3) health education so as to enable the child to learn and practise personal hygiene;
- (4) correction of defects of nutrition through a properly balanced midday meal and
- (5) physical education by gymnastic exercises and corporate recreational activities.

Adequate nutrition and physical education are so important not only from the point of correcting existing defects in the child but also from that of endowing him with an abundance of health and vigour and with the power to enjoy life that no school health programme can be considered satisfactory without including these within its scope. In India school health services do not exist in most parts of the country and even where they exist, the organisations are not, at present, functioning on the comprehensive lines indicated here.

#### Development of School Health Administration in India\*

2. School medical inspection was started first in Baroda city in 1909. In the succeeding years practically every province introduced some form of school health programme but the area covered by the service varies widely as well as the types of schools in which medical inspection is carried out. The schemes seem to cater more for middle and high schools than for primary schools. The Joint Committee of the Central Advisory Boards of Health and Education drew special attention to the frequency with which a system of medical inspection was started in the Provinces, only to be abandoned after a short while as a measure of economy. There are a number of instances of change in policy which seem to indicate that there has not been a clear appreciation of the fundamental necessity for, and of the essential characteristics of, a school medical scheme calculated to promote the health of the school child. The Committee emphasised that satisfactory arrangements for school medical inspection and treatment should form an essential part of any efficient system of public education. The conclusion reached in the report was that, with certain exceptions, school

\* These brief notes on the development of school health services in India are based on the information contained in the Report on School Medical Inspection of the Joint Committee of the Central Advisory Boards of Health and Education (1941).

health work in British India is carried on in a perfunctory manner. Environmental hygiene is striking in its absence, particularly in the rural areas. Medical inspection is undertaken with inadequate provision, in many cases, for the treatment of the defects which are detected and with even less provision for preventive work through a follow-up service. Health education has produced little tangible results.

Brief descriptions of school health work in a number of provinces are given below:—

3. *The United Provinces.*—The medical staff employed on school health activities consist of (1) medical officers with public health qualifications, who are employed on school health work alone, in 13 of the larger towns in the province and (2) district and municipal medical officers of health in other parts of the province, who do this work along with their other duties. Two types of inspection, based on a difference in the degree of thoroughness, are being carried out. They are (a) “ordinary” for vernacular middle and primary schools in urban and rural areas and (b) “detailed” in English High and Middle Schools, English Normal Schools and Intermediate Colleges. In 1943, as regards (a) mentioned above, of 596 institutions under the scheme 248 were visited by the school medical officers and medical inspection was carried out in respect of about a fifth of the total of 72,600 pupils on the rolls. In rural areas, about a fifth of the total number of 10,597 schools was visited and approximately one-seventh of the 736,300 pupils on the rolls was examined. As regards treatment facilities, a central clinic has been established in each of the 13 towns where whole time school medical officers are employed. At these clinics treatment is given by the school medical officers for simple ailments and defects found during their inspections. In a certain number of places the free services of specialists have been secured for ophthalmic and dental cases. The total expenditure of Rs. 30,000 per annum on these clinics is met by a charge of one anna per month recovered along with his fees from each pupil in the institutions under the scheme. A portion of this expenditure is earmarked for the free supply of glasses to poor students and of milk to ill-nourished children who are unable to pay for it. In other urban centres provision for treatment is restricted to the supply of a stock of simple medicines to the schools concerned for administration by the medical officer of health during his inspection or under his advice by the teachers. The position regarding treatment is even worse in rural areas where the existing dispensaries are situated at great distances from one another. Even here, however, some provision is made for elementary medical needs by the supply of first-aid equipment to schools through the Junior Red Cross Organisation.

4. *Bengal.*—In this province an Assistant Director of Public Health devotes his whole time to this branch of health administration. Since 1928 a scheme of school medical inspection has been in existence in Calcutta city. This scheme extends to all Government and Government-aided secondary schools in the city with

approximately 10,000 pupils. Four school medical officers are employed on this scheme. Provision for the treatment of the defects discovered during medical inspection is meagre. An annual sum of about Rs. 650 is available for the purchase of all the appliances required and of drugs and an additional sum of Rs. 300 per year for the free supply of spectacles to poor students.

As regards other towns it is stated that, in the 29 municipalities out of a total of 117, which employ health officers, school medical inspection is also done by these officers as part of their routine duties. Similarly in the areas of three district boards the District Health Officers are said to perform this work also in addition to other duties. No special provision seems to exist for giving treatment to the pupils in whom defects and disabilities are discovered.

5. *The Punjab*.—In the rural areas there are five selected districts in which centres within a radius of two miles from a dispensary come under a scheme of school health service. The scheme, which is in its infancy, is far from elaborate. In some of the larger urban areas in the province, schools have combined to engage a whole-time doctor who conducts medical inspections and carries out treatment. These schemes are self-supporting, students from the fifth class upwards contributing a medical fee of Rs. 1-8 per annum per head. The teachers are also included in the scheme and they contribute Rs. 3 each, per annum. In a few of the smaller towns in the Punjab students of the secondary schools pay two annas per month and in return are examined once a year and receive a certain amount of medical attention.

6. *Delhi Province*.—In New Delhi the school medical service covers a population of about 4,000 students. The scheme is under the control of the Chief Health Officer, who has a man and a woman doctor to look after the schools for boys and girls respectively. The New Delhi municipality also employs a dentist and an oculist on a part-time basis for providing these services to the school children. Treatment for minor ailments is provided. A part of the cost is recovered from the pupils by charging them a fee of two annas per month and the share of the municipality towards the cost of the scheme is about Rs. 8,000 annually. In Delhi city two school medical officers, who are servants of the Provincial Administration, are employed. They are controlled by the Chief Health Officer. The service is not so well organised as in New Delhi.

7. *Madras*.—In Madras City there are four full-time medical inspectors, two medical inspectresses and two part-time specialists to work in school clinics. There are also special clinics for ear, nose and throat cases while those suffering from eye and dental affections are referred to the local hospitals. Outside Madras City there is no school medical inspection service except in certain schools where the authorities concerned have introduced such inspection.

8. We do not propose to describe the school health services in other provinces because they present no material differences from the organisations we have outlined above.



9. Before we close this chapter we shall refer to two other aspects of the school health problem. The first is the nutrition of school children. The Joint Committee's report, to which we have referred above, has pointed out that "In many parts of India it is the custom for children to have a meal before they leave for school and have no more food until they return home in the late afternoon. Such children cannot be expected to have the necessary energy to devote themselves to their school tasks. It is essential, both from the point of view of education and of health, that all the children should be given a midday meal, whether it is brought by the children from their homes or provided at the school by the authorities". We fully endorse this view. We find from this report that, in certain of the provinces in which school health services have been operating, the authorities concerned have realised the value of a midday meal for school children and that, of the total expenditure on school health services, a high proportion is set apart for school meals. Examples are Madras city with a provision of Rs. 67,000 for supplementary food and an allotment of Rs. 12,000 for the school medical staff, and Bengal with a provision of Rs. 45,000 for food and Rs. 7,800 for medical inspection and treatment. The growing child is particularly susceptible to the adverse effects of malnutrition and under-nutrition and no school health scheme can be considered satisfactory unless the provision of a balanced midday meal forms part of the scheme.

10. The other aspect of the school health problem is the existing low standard of sanitation in many schools, particularly in the rural areas. Even those schools which are housed in buildings constructed for the purpose do not, in many cases, conform to modern standards. A large number of schools are housed, however, especially in rural areas, in rented buildings in which the sanitary condition, the arrangement of the class rooms as regards lighting and ventilation and the provision of proper lavatory and washing facilities, all leave much to be desired. The theoretical instruction regarding personal hygiene, which is given to the students in the class room, must necessarily fail to influence their life in the absence of these essential facilities to enable them to practise what they are taught.

## CHAPTER VIII.

### HEALTH OF THE INDUSTRIAL WORKER.

#### Definition of Industrial Population

1. Before beginning to discuss the health problems of industrial workers it is desirable to consider what sections of the community should be included within this category. The conditions affecting the health of a worker may, broadly speaking, be divided into two groups, namely, those which he shares with the other members of the general community among whom he lives and those which are associated with the occupation he pursues. In regard to the latter there may be special hazards to health arising out of particular occupations. The development of anthrax by those handling wool or skins and hides or poisoning by lead, chrome and other substances which are used in a variety of trades or manufacturing processes are examples of such special hazards. There are also other factors which have their influence on the health of the worker and these include the lighting, ventilation and general sanitation of the workshop or factory, the dust and noise associated with the working environment and the provision that exists for rest pauses, meals and personal cleanliness. It seems correct to hold that, over and above the general provision for health protection which the worker can share with the other members of the population, he has the right to claim that special measures should be taken to counteract the adverse effects of those factors which are associated with his occupation. The provision of such special health measures is the function of an industrial or occupational health service. We believe that, to a greater or less extent, all those who are gainfully employed outside their own homes will require the services of the occupational health organisation. While recognising this as the ultimate objective we consider that, as an interim measure, the term, "Industrial population", may with advantage be limited to the classes shown below:—

Persons employed in—

1. establishments governed by the Factories Act;
2. unregulated factories;
3. mines;
4. the building industry;
5. large public works;
6. transport organisations including railways, roads, inland waterways, high seas and docks;
7. plantations, tea, rubber, coffee, sugarcane and cinchona;
8. distributive trades including retail shops and
9. restaurants and hotels.

#### An Estimate of the Probable Number of Industrial Workers

2. The number of workers in certain of the classes shown above is not known. Such information as is available is given below.

# CHAPTER VIII

The average daily number of workers, in 1942, in various types of establishments governed by the Factories Act, are quoted from a Government return:—

	Perennial.	Seasonal.
Government and Local Fund factories . . . . .	299,273	620
<i>All other factories—</i>		
Textile . . . . .	965,459	...
Engineering . . . . .	223,820	...
Minerals and Metals . . . . .	82,493	...
Food, Drink and Tobacco . . . . .	121,311	162,317
Chemicals and Dyes . . . . .	72,626	1,507
Paper and Printing . . . . .	48,501	...
Wood, Stone and Glass . . . . .	82,334	...
Gins and Presses . . . . .	17,029	134,670
Skins and Hides . . . . .	29,608	...
Miscellaneous . . . . .	38,465	2,204
<b>TOTAL</b> . . . . .	<b>1,980,919</b>	<b>301,318</b>
<b>GRAND TOTAL</b> . . . . .	<b>2,282,237</b>	

It has not been possible for us to obtain estimates of the number of persons employed in certain occupations. These include workers in unregulated factories, the building trade, large public works, inland waterways, docks, motor road transport, sugarcane and cinchona plantations, retail shops, restaurants and hotels. Such figures as we have been able to secure are given below:—

1. Transport workers—	
(a) Railways . . . . .	774,380
(b) Tramways—	
(i) Calcutta . . . . .	6,000
(ii) Bombay . . . . .	4,000
2. Indian seamen . . . . .	92,900 (latest figure available is for 1929 in Bengal and Bombay).
3. Tea . . . . .	588,163 (Assam), 196,899 (Bengal). 930,412 (South India).
4. Rubber . . . . .	48,704
5. Coffee . . . . .	92,504 (South India)

The figures quoted above for factory workers and others give a total of a little over 5 millions and if those categories of workers, for whom no estimates of possible numbers could be made, are also included, the total industrial population as defined by us is likely to be in the neighbourhood of at least 7 or 8 millions, if not more.

### **Certain Preliminary Considerations**

3. While industrial workers all over the world require special health measures for reasons we have already indicated, we believe that, in India, the need for protecting the health of this section of the community is even greater. In the highly industrialised countries of the West the industrial population is more stable than in India. The industrial worker in India, on the other hand, is generally a migrant from the rural areas and continues to keep contact with his home. He lives and works in a more congested and unhealthy environment than that to which he had been accustomed. He often lives separately from his family and exposed to the temptations that urban conditions provide. The incidence of disease is therefore high among these workers and the continuous exchange of industrial population, which takes place between the large urban centres, where industries generally exist, and the rural areas, has already been recognised as a fruitful source of the spread of infectious diseases such as tuberculosis and leprosy. In the urban areas themselves the existing conditions of overcrowding and insanitation are largely associated with the influx of industrial workers, who live widely dispersed among the general population. A high incidence of disease in the former has therefore its repercussion on the health of the community both in industrial areas and in the villages.

4. The war has aggravated the previous conditions of overcrowding in all industrial areas. For instance, the population of Cawnpore was at the 1941 census about 487,000. In October 1944, when we visited the city, we were told that its inhabitants numbered approximately 800,000. A similar abnormal rise in population has been reported from Calcutta, Bombay and other industrial centres. The result has been to produce overcrowding on an unprecedented scale, as the increase in housing accommodation has fallen far short of the rise in population. We draw special attention to this state of affairs because a possible result of further development of industry in the post-war period may be to aggravate existing conditions of overcrowding, unless adequate measures can be undertaken to safeguard against such a possibility. Minimum standards for housing, which would ensure the health of the workers, will have to be laid down. We are confident that the enforcement of these standards is not likely to arouse any great opposition. Indeed, enlightened industrialists have repeatedly expressed before us the view that they would welcome the laying down of such standards. We shall deal with overcrowding in greater detail, later in this chapter, in the section relating to housing.

We shall now take up, for brief consideration, the different aspects of the industrial health problem.

### **Morbidity and Mortality among Industrial Workers**

5. No reliable figures of morbidity and mortality among industrial workers are available. The machinery for providing such information does not exist at present. Many factories have no dispensaries and hence a reliable record covering all industrial

workers cannot be had. Further, the information available from such industrial establishments as maintain dispensaries or hospitals is incomplete. Reasonably complete morbidity statistics are likely to develop only if there be health insurance for the workers, which provides for the certification of sickness before they become eligible for cash benefit. Such a scheme is, broadly speaking, non-existent in the country. The deaths among industrial workers are included in those for the community as a whole and are not shown separately in the statistics which the authorities publish. In the circumstances we do not propose to put forward certain figures which came to our notice.

6. Living in the midst of the general population industrial workers are subject to those diseases which are prevalent among the former. In addition they are also subject to other causes of morbidity and mortality associated with their occupations, particularly those which are of a hazardous nature. As regards general diseases, their prevalence among industrial workers must at least be as high as in the population as a whole. For reasons to which we have already referred we think it probable that the incidence of certain of these diseases might even be higher among industrial workers, particularly of tuberculosis, bronchitis and asthma.

7. Little information is available regarding the incidence of occupational diseases in India. In England medical practitioners are required to notify, under Section 73 of the Factory and Workshop Act, 1901, certain diseases contracted in a factory or workshop. In India, no such provision exists under the Factories Act. Anthrax is notifiable under the local Self-Government Acts in certain provinces, although not as an industrial disease. But no statistics relating to its incidence are available. Under the Workmen's Compensation Act a list of diseases has been declared to be occupational diseases. Compensation is payable by the employer to a workman if he has been continuously in employment for a period of not less than six months and has contracted any of these diseases during that period. The number of claims made in a year is, however, very small—probably less than 10—so that these figures give no indication as to the probable incidence of industrial diseases.

### Medical Relief

8. *Provision inside the factory.*—The Factories Act enables Provincial Governments to make it obligatory on an industrial establishment to make provision for first aid. We are satisfied that the first aid arrangements provided by the great majority of the factories come up to the standard laid down by the Factories Act. As regards dispensaries run by industrial establishments, with some exceptions, the position is not so satisfactory. Drugs and equipment are, in the majority of these dispensaries, in short supply. There was a general complaint of shortage of quinine, particularly in Bengal, Bihar and the United Provinces.

9. *Provision outside the factory.*—The general conclusion that we have reached as the result of our survey of the total provision

for medical relief outside the factory for industrial workers by Governments, local bodies, employers and private practitioners is that the existing facilities must be considered to be, on the whole, quite inadequate.

10. The facilities provided by Provincial Governments and local bodies for industrial workers are, generally speaking, those available for the community as a whole. The grave insufficiency of such provision for the community has been pointed out, in some detail, in Chapter III of this volume of the report. Large industrial centres are either large cities or are in close association with them. In such places the provision for medical relief may be expected to be higher than that for the country as a whole. Nevertheless, the existing facilities are inadequate to meet the requirements of the workers. We may illustrate this by a brief reference to three industrial centres Ahmedabad, Cawnpore and the Hooghly industrial area. The population of Ahmedabad at the 1941 census was nearly 600,000. It is certain that this population must have increased considerably in the succeeding years, although we are not in a position to estimate the rise. The total number of hospital beds available in Ahmedabad is 380. There are some 350 men and 25 women medical practitioners. An out-patients dispensary is run by the Textile Labour Association of Ahmedabad. These facilities may be considered to be better than those which exist in some other towns. But, considering the size and needs of this large city, the total provision for medical aid seems to be quite inadequate. In Cawnpore the Provincial Government maintains a general hospital and a women's hospital. Factory employers, under a combined scheme, run the McRobert Gunj Hospital for mill assistants only, *i.e.*, upper class factory workers. In addition there is an American Mission Hospital for women and children. The total number of medical practitioners in the city is about 100. The Medical Officer of Health, Cawnpore, states that the available medical facilities were insufficient for the inhabitants of the city with its normal population of two to three hundred thousand, which has increased to 800,000 owing to the influx of labour under war conditions, while the provision for medical aid has remained the same. As regards the Hooghly industrial area the Chief Inspector of Factories, Bengal, stated that "medical relief whether by way of institutions provided by Government or otherwise, or private medical practitioners, is inadequate to meet the needs of both the general and industrial communities. Staff, equipment and drugs are also inadequate."

11. It must be pointed out that, although we have included the general practitioners in each area as part of the provision for medical relief, a large proportion of industrial workers is unable to pay for and obtain the services of such practitioners. They must depend mainly on the out-patient and in-patient departments of hospitals and on the dispensaries maintained by the public authority or on institutions provided by employers.

12. Special reference is necessary to medical facilities in plantations and mining areas. From the evidence we received and from our own observations the existing provision in plantation areas leaves much to be desired. The dispensaries maintained in two plantations which we visited in South India were of a low standard. One of these was in charge of a homeopathic doctor and stocked homeopathic drugs as well as those used in modern scientific medicine. Both dispensaries were small in size and the standard of cleanliness was definitely low. Conditions in the Dooars plantations in Bengal cannot be said to be better.

13. At the same time reference should also be made to better conditions elsewhere. From information received from the Secretary of the Planters' Association of South India, the plantation districts of the Anamalais, Nilgiris Wynaad, South Nilgiris, Travancore and Central Kanan Devans together have an area of 250,000 acres and employ about 200,000 labourers. The total hospital accommodation available in the area is 1,270 beds in 81 hospitals. This cannot be considered as an insufficient provision as it represents 6 beds per 1,000 of the population, which is about 25 times that which is now available for the general population in the country as a whole. In some of the larger hospitals graduates in medicine are employed, while the smaller plantations utilise the services of medical licentiates. In the Nilgiris, however, some plantations have even compounders in charge of their medical institutions.

14. Provision for medical relief in the coal-mines of Raniganj, Asansol and Dhanbad are not, speaking generally, satisfactory. We noted that some collieries employed medical licentiates, on a part-time basis, for Rs. 15 or Rs. 20 per month. This is the salary of a peon and it does not seem unreasonable to expect that the service which the miners would receive for such salaries would be comparable in value.

### **Rehabilitation**

15. This important aspect of medical relief for workers has hardly been developed in the country. We did not find, during our tours, in any industrial area a centre which undertakes the rehabilitation and retraining of the worker, so as to enable him to take up work again after he had been disabled by an accident. Provision for the supply of artificial limbs and artificial eyes is also quite inadequate.

### **Accidents**

16. The rules relating to accidents, which have been framed by Provincial Governments under the provisions of the Factories Act, appear to be adequate and they are, generally speaking, followed by most of the larger concerns. There is, however, evidence to show that some of the smaller establishments try to evade the notification of accidents.

17. Accidents are classified as fatal, serious and minor. The following figures for the total number of accidents in British India relate to the year 1942:—

Fatal	.	.	.	.	.	.	.	.	.	323
Serious	.	.	.	.	.	.	.	.	.	9,111
Minor	.	.	.	.	.	.	.	.	.	44,740
TOTAL										54,174

18. In those factories in which dispensaries and hospitals exist, the treatment of patients is undertaken at these institutions. Where such provision is not available the cases are sent to local public institutions. Very few factories possess their own ambulances. Many utilise the factory lorry or car. In several instances it was reported to us that workers had to make their own arrangements for conveyance to hospital.

19. Abolition of the defence of common employments makes employers responsible for compensation in many cases of accidents. This probably leads to reluctance to notify accidents in the case of certain employers. But we have reason to think that, with the growth of the trade union movement, workers are becoming better organised and more conscious of their rights. It has not been possible for us to examine in detail the working of the Workmen's Compensation Act. Reference should, however, be made to the representation received by us from certain organisations that cases under the Act have a tendency to drag on in some provinces in which Compensation Courts sit only twice a year. Some industrial establishments have insured themselves against the claims of workmen for compensation and no difficulty arises in such cases for the payment of compensation. In other establishments disputes between employers and employees are not uncommon. These disputes are settled in the Court of the Commissioner for Workmen's Compensation or by the District Magistrates who are Commissioners for this purpose in their districts. The trend of evidence is that, in the majority of cases, the claim of the worker is upheld by the Court. It has been represented to us that, on certain occasions, the amount of compensation sanctioned is inadequate, for instance, a sum of Rs. 900 for the loss of a right arm.

20. We believe that there is a case for a simplification of the procedure laid down in the Workmen's Compensation Act and that this question deserves early consideration.

#### **Sanitation, Lighting and Ventilation of Factories**

21. Legal provision for ensuring the health and safety of the worker has been made in Chapter III of the Factories Act. Section 13 of the Act lays down that "every factory shall be kept clean and free from effluvia arising from any drain, privy or other nuisance and shall be cleansed at such time and by such methods as may be prescribed". We consider it essential that such Provincial Governments as have not framed rules under this section should do so without delay, because, from the point of view of the health



of the worker, it is necessary that certain minimum standards of cleanliness inside the factory should be laid down and enforced.

22. Under Section 14, the Provincial Government has the power to prescribe that every factory shall be ventilated in accordance with such standards and by such methods as may be prescribed. We understand that rules under this head have been framed by every Provincial Government except that of the Punjab and the evidence before us suggests that the observance of these rules is reasonably satisfactory.

23. In some of the textile mills workers complained that humidification was overdone to such an extent as to interfere with comfortable working conditions, it being stressed by some of the workers' representatives that such increase in moisture was made by factories using the cheaper quality of yarn in order to prevent their frequent breakages. This is a matter for expert investigation.

24. Progress has been made for protection against dust in the large textile industries, but the position in jute mills is unsatisfactory. Dust was in evidence in the blow rooms and in the bleaching departments. Similarly, in cement factories in Southern India, there was considerable evidence of dust in the crushing mill and in the packing departments. In some of the places we visited the workers were found protecting their nostrils by tying the end of their turbans round their nose. In no place did we notice that the workers were provided with masks.

25. Section 15 of the Act, which deals with cooling arrangement in factories, has worked reasonably satisfactorily in the factories which we visited. In some of the factories we found that effective air-conditioning devices have been installed. Air-conditioning, besides ensuring higher efficiency and aiding in the manufacturing processes, contributes much to the comfort and well-being of the workers.

### **Drinking Water Supply**

26. The provision of water supply in factories is regulated by section 19 of the Act. We found that, in some factories, workers had to walk long distances for drinking water. In certain cases drinking water supplies were kept not far from latrines. In some establishments we noted that the salary of the waterman had to be paid by the employees. We are particularly drawing attention to such matters because we consider that it should be obligatory on all owners of factories to provide, free of charge, safe and cool drinking water in adequate quantities to their workers and that it should be readily accessible to them.

### **Personal Cleanliness of the Workers**

27. Washing and cleansing facilities cannot be considered adequate in many industrial establishments we visited. This remark applies particularly to the mining industry. It may, however, be mentioned that the Tata Coal Mines, Dhanbad, provide

reasonably adequate arrangements for these purposes and their example may, with advantage, be followed by other establishments.

### **Special Clothing and Protection of the Eye of the Worker**

28. The provision of special clothing in certain occupations is of great importance. The attitude of the representatives of trade unions, who appeared before us, was that they would welcome protective clothing provided it was supplied by factory owners. It was urged that the wages which employees received would not enable them to purchase such clothing even at cost price. The need for such special protective clothing cannot be over-emphasised in the case of those occupations which are likely to soil the clothes of the worker or produce specific risk to his health in the absence of such protection. The Cordite Factory at Coonoor has given a lead in this direction.

29. The wearing of protective eye glasses is not strictly enforced even where employers provide them. We found them hung up on walls in many cases. The chance of foreign bodies getting into the eyes is not negligible in certain occupations. The damage done may lead to serious consequences involving, in some cases, loss of sight to the worker and the payment of heavy compensation by the employer. It may be that the disinclination of the employees to use glasses is due to their unsuitable design, in as much as they are, in the majority of cases, of the closed goggle-type with no ventilation to the eye.

### **Urinals and Latrines**

30. Rules made by the Governments of Bombay and Madras under the provisions of the Factories Act require that factory owners should provide one seat for every 50 workers where the total number of employees exceeds 200. We have no information as to what standards have been prescribed by other provinces.

31. We were particularly struck by the absence of urinals and latrines in coal-mines. We were informed that miners used the goafs and unused galleries as latrines and that sweepers went round cleaning them. The inaccessibility of some of these places and the darkness that prevails in them make it doubtful whether proper cleaning will ever be carried out. The incidence of hook-worm infestation among the mining population, as shown in a report of the Asansol Mines Board of Health, appears to be high. Among colliery workers the percentage of infestation was 68·8, while the corresponding percentages for the rural and town populations were only 37·1 and 18·6 respectively. The Royal Commission on Labour commented adversely on the sanitary conditions that existed underground in the coal-mines and recommended that bucket latrines should be provided at convenient spots and a suitable staff of sweepers employed to keep the latrines clean. This recommendation has not been carried out and the conditions that prevail are much the same as those on which the Royal Commission commented.

## Housing

32. By far the most important matter that we have had to consider in connection with the health of the industrial worker is the housing problem. We are not satisfied with the housing conditions prevailing in any of the places we visited. Overcrowding is a feature common to all these centres. Further, the hygienic condition of the houses and their surroundings is, in most cases, very unsatisfactory. Certain recent figures presented by the Chief Engineer of the Calcutta Corporation show that 27 per cent. of the population in that city live in *bustees*. Yet, under the existing City Municipal Act, land owners are responsible for the sanitary and hygienic conditions in them! The Bihar Labour Enquiry Committee report of 1940 made strong remarks about the housing of labour in industries adjacent to or within the limits of municipalities or even in rural areas. The report of the Rent Enquiry Committee of the Bombay Government shows that, some years ago, in Ahmedabad there was already a deficit of over 20,000 working class tenements. The Textile Labour Enquiry Committee reported that, in Bombay in 1936, the employers provided some 4,000 odd tenements, three quarters of which were single room habitations, against a working class population of over 150,000. In Ahmedabad less than 3,000 (the majority being single-room tenements) were provided for over 100,000 workers. In the tenements constructed and owned by the Government of Bombay, 63,000 persons in 1939 were housed in 13,000 rooms. An enquiry conducted in 1938 by its Labour Office showed that 91.24 per cent. of the families covered by the enquiry lived in one-room tenements; the average number living in each had arisen in 1941 to 4.01. In 1938, 74 per cent. of the population of Bombay lived in one-room tenements, which constituted 84 per cent. of the total tenements in the city. In the same years, 62 per cent. of the families in Cawnpore and 63 per cent. of the families in Lucknow lived in one-room tenements. In Bengal, at the outbreak of the war, there were only 40,000 one-room tenements for nearly 150,000 workers in the Calcutta and Howrah area. The activities of Improvement Trusts and Municipalities have made little impression upon the housing difficulties of industrial workers, though in some places they have relieved the housing difficulties of the middle-classes.

33. The assumption underlying the majority of working class housing schemes has been in the past that workmen and their families need only single-room tenements. In such quarters the observance of the ordinary decencies of life is impossible. Further, as the room has generally to meet all the requirements of the family, including cooking, living and sleeping, it becomes impossible to keep it reasonably clean and sanitary. The filth and squalour which we saw in the *ahatas* of Cawnpore or the *bustees* of Calcutta are indescribable. A dark dingy room of about 10 ft. by 8 ft. in size, built in such a manner that neither light nor air can enter it and with, as in the case of the coal-mines area, as many as 8 or 10 persons not infrequently living in it, represents the type of living accommodation which workers have to accept in

these congested industrial centres. Washing and bathing facilities as well as latrine accommodation are often non-existent. Indeed, men and women have to go sometimes two or three furlongs in muddy roads and without light to answer the calls of nature. The inconvenience they have to undergo is aggravated during rains. We have taken Cawnpore and Calcutta as examples. The position is no better in other large industrial cities such as Bombay, Ahmedabad, Madras and Coimbatore. In the plantations we were shown quarters into which we could enter only by crawling. In the coal-mines area housing conditions are equally unsatisfactory.

34. As against this dark picture reference must be made to the efforts that certain enlightened employers have made to ameliorate the housing condition of their workers. We particularly desire to mention, in terms of appreciation, the housing scheme for workers which the Madras mills have started. In Harveypatti we saw spacious grounds, detached quarters with two rooms 10 ft. by 10 ft., a verandah, a court-yard, a separate latrine, bathing place, a garden and a small plot where flowers and vegetables could be grown. The houses are built by the company but a worker can acquire proprietary rights over it after paying a rent of Rs. 4 per month for a period of 12 years. Some other employers have also attempted to solve, at least partially the housing difficulties of their workers by providing quarters for them. In this connection reference may be made to some of the places visited by us, the Delhi Cloth Mills, Ltd., and the Birla Mills at Delhi the Tatas and the Indian Steel and Wire Products at Jamshedpur, the Batas and some of the Jute Mills in the Calcutta industrial area, the Spring Mills in Bombay, the British Indian Corporation and the Begg Sutherland group in Cawnpore. Some of these housing schemes are good, some of indifferent quality while others are unsatisfactory. We noticed a desire on the part of employers to help in the solution of the housing problem, but their main grievance was that neither sites nor building materials were available in war-time. Employers cannot, even in the post-war period, carry out any large scale housing programme for their workers unless they are helped to secure sites for building purposes. In this connection the question of such legislative and administrative action as may be necessary has been considered in Volume II which deals with our recommendations.

### **Nutrition of the Worker**

35. The diet of workers in factories, mines and plantations is generally of a low standard and lacks the essential nutritive elements. We were particularly struck with the low quality of the staple diet of workers in Madras and Bengal. The position in regard to milk consumption is unsatisfactory in all parts of the country. The average level of wages in Bombay and Ahmedabad is higher than in other places and, from the evidence we collected, we have reason to believe that a more nutritive diet is taken by workers in these two cities than in other parts of India.

36. In the Province of Madras and in Jamshedpur an effort has been made to encourage workers to take meals at regular hours. The provision of facilities by way of canteens inside the factory and a system of proper rest pauses should go a long way to change the present irregular habits, in the case of many workers, in respect of time of meals. We saw an excellent canteen in Arvind Mills in Bombay and another at the Century Mills. In both places the arrangements for serving food to the workers were satisfactory. Seating accommodation for each person was provided separately and food was served in *thals* on neat little tables. The cost of a full meal at the Century Mills was said to be As. 2-9. The Tata Iron and Steel Co., Jamshedpur, maintains canteens and hotels at which excellent meals, much below the prices in the local bazaar, are served. Another good canteen we visited was the one run by the Radhakrishna Mills at Coimbatore. Bombay seems to have given the lead in this matter to the rest of the country and we understand that there are some 113 canteens in the Province, 16 of them supplying cooked food while the majority serve tea and refreshments only. The textile industry runs 85 of these canteens. In Madras, Bengal and Northern India, we were told by many employers and some employees that the social habits of the people and their caste prejudices are impediments to the development of the canteen system. But caste prejudices are gradually dying out. While it may be necessary to make separate provision for orthodox and unorthodox workers in the beginning, we have little doubt that, in due course, these prejudices will disappear. In fact the development of the canteen system may have a salutary effect in this direction.

37. In some of the factories we visited co-operative stores and societies were in existence. The Cordite Factory, Coonoor, the Madura Mills and the Arvind Mills have well organised co-operative Stores. At the Cordite Factory Stores fresh vegetables and fruits were available to the workers. The development of co-operative stores and of the co-operative movement among workers requires fostering.

### Hours of Work

38. We realise that there is an economic aspect to the question of regulating the hours of work and we do not feel confident to speak with authority on this subject. But there is also a health aspect which we cannot ignore. The number of hours an individual is called upon to work has a bearing on his health. Long hours lead to fatigue which, if continued from day to day, injures the health of the employee, reduces his working capacity and increases his liability to accidents. The Factories Act of 1934 has laid down maximum hours, under normal conditions, for perennial factories as 54 hours per week and for seasonal factories 60 hours. The principle of a 48-hour week was accepted by the Washington Convention in 1921. In recent years the tendency has been to stress the need for an even smaller figure. Before the war the United States and France were, generally speaking, working 40

hours per week. In Great Britain the Factories Act merely prescribes hours of work for women and children and leaves those affecting men to be regulated by collective bargaining. Effective trade union organisations have helped the employees to achieve, for all practical purposes, a 45-hour week in Great Britain. The question for consideration is whether, in the interest of the health of the Indian worker, a reduction in the prescribed hours of work is desirable. He has, generally speaking, a poor physique. His standard of nutrition is low. He has no clean surroundings to live in. These are matters which should be taken into consideration in arriving at a decision as to whether the longer hours prescribed in India as compared with those laid down in the countries mentioned above, are justified from the point of view of the health of the worker.

We must record that enlightened employers are in favour of shorter hours of work, and in our recommendations we have, taking into consideration the health point of view, made a specific suggestion that a forty-five hour week should be adopted.

### **Transport**

39. Transport facilities for workers were reported to be inadequate in almost all the centres we visited. Workers who live at a distance have to walk as many as four or five miles to and from work. When it is remembered that the Indian labourer has to work in perennial factories 54 hours a week and in seasonal factories 60 hours, it will be seen that the question of transport assumes considerable importance from the point of view of his health. The long hours he has to work and the distance he has, in many cases, to walk to and from the place of work would result in fatigue, which must have its adverse effect on his health and efficiency. The question of transport is intimately connected with that of housing. While in some of the smaller places it may be possible to provide working class quarters in areas not too far from the factories, such provision has to be ruled out in the case of large cities like Bombay, Calcutta, Ahmedabad and Cawnpore. In these towns new housing schemes can obviously be undertaken only in suburban areas situated at considerable distances from the factories. In these circumstances the provision of cheap transport is essential. The extent to which transport facilities should be provided is a matter for local investigation.

### **Rest Shelters**

40. Rest shelters, where they were provided, were found to be, in almost all cases, sheds with corrugated iron roofs and with cement or brick floor. We do not approve of such roofing material, which will become heated up in the summer. Many employers said that, in factories which have open space and shady trees, workers prefer to rest during certain periods of the year in the open under the trees. It must be remembered that the sun in the summer is hot in most parts of this country and that workers need and appreciate protection against sun and rain. It is undesirable,

from the point of view of their health, that workers should be allowed to remain inside the factory during rest hours. We saw in several factories workers sleeping inside steel boxes meant for the storage of bobbins. In some places we noticed them taking their meals near their machines on bales of cloth or seated amidst dirty surroundings. The plea that workers hesitate to use rest shelters for taking food on account of caste prejudices is not convincing. If rest shelters are provided, workers will find their own favourite spots and will form their own little groups in the same manner in which the better classes form groups in their clubs.

### **Drink and Drug Habits**

41. The prevalence of drink and drug habits varies from province to province and in the different industrial areas in the same province. An analysis of the evidence available to us shows that these habits may be described as excessive in eight industrial centres, moderate in four, decreasing in six and on the increase in five centres. The question of restricting the use of alcohol by industrial workers will have to be considered both from the point of view of its direct effect on the health of the worker and from that of preventing, as far as possible, the diversion of a portion of his meagre resources from essentials such as food, clothing and shelter for himself and his dependents to intoxicant drinks and drugs for the purpose of a temporary sense of well-being and freedom from care.

### **Women Industrial Workers and Special Provision for them and their Infants**

42. We should like to draw special attention to the lack of sufficient facilities for health work among women factory labour and to the inadequacy of the available number of women doctors, nurses and health visitors for work of this nature.

43. The employment of women workers makes it essential that there should be provision for nurseries or creches where their children can be left and given proper food and attention while the mothers are away at work. The Indian Factories Act has empowered Provincial Governments to make rules (a) requiring that, in any specified factory where more than 50 women are ordinarily employed, a suitable room should be reserved for use by the children of such women, who are below six years of age and (b) prescribing the standards of such rooms and the nature of the supervision to be exercised over the children therein. The Government of Bombay have made rules for the provision of creches in factories where 100 women are employed. The Government of Madras has not, so far, made any rules in this connection. The position in regard to the provision of creches is worse in Madras than in Bombay, though there are some good creches in some of the larger mills. The absence of a statutory obligation, however, makes employers indifferent about providing creches. In Bihar provision has now been made for the establishment of creches if the number of women workers in a factory

exceeds 50. In Bengal the provision of creches is not a statutory obligation. Some of the larger concerns, including the jute mills, have, however, voluntarily established them and have also included the supply of milk and supervision for the children. The standards reached by these creches in respect of such provision are not, however, satisfactory. In the United Provinces Section 16 of the Maternity Benefit Act, 1938, gives power to the Provincial Government to make rules for the provision of creches and for their supervision. Rule 11 framed under this Act lays down the standards in regard to creches. Milk for babies and children is provided, free of charge, at these creches. Existing creches in the plantations in the Dooars are not working satisfactorily, the chief defect being absence of arrangements for feeding the children while their mothers are away at work.

44. Maternity Benefit Acts are in existence in all provinces except Bengal, Bihar and Orissa. In the first two, however, we understand that women are receiving maternity benefit in the case of all the larger industrial establishments, including plantations. The maximum period for benefit allowed under the different Provincial Acts four weeks before and four weeks after childbirth. Under the International Labour Convention the period recommended is six weeks in both cases. The grant of maternity benefit is of great importance from the point of view of the health of the mother and of the child. In India infant and maternal mortality rates are high. Therefore the need for giving the woman worker the period of rest regarded as necessary under the International Labour Convention must, in our view, be recognised.

45. We were assured that the enforcement of the Maternity Benefit Acts did not result in any decrease in the number of women employed in the provinces of Madras and Bombay. In order to enable a woman to obtain maternity benefit, certification of her pregnancy is necessary. We are not satisfied with the existing facilities for the certification of pregnancy. Women doctors are not ordinarily employed in dispensaries and industrial areas generally suffer from an acute shortage of them. We understand that some women are reluctant and even definitely object to submit themselves to examination by men doctors.

### **Factory Inspection**

46. The factory inspection staff in the provinces is at present quite inadequate. The Commissioner of Labour in Madras considered that it is not possible for an inspector to do more than 250 inspections satisfactorily in a year. The evidence given before us goes to prove that the factory inspection staffs require strengthening in all the provinces. In our opinion the aim should be to have the staff sufficiently strengthened to ensure the inspection of all factories at least twice a year.

47. One of the questions to which we gave some attention was that of elementary training for factory inspectors in public health. The Chief Inspector of Factories, Bengal, considered that, at the



present stage of industrial development, such training was unnecessary. On the other hand the Chief Inspector of Factories, United Provinces, took a different view. He said that training in public health would enable an inspector to administer more satisfactorily the safety and welfare provisions of the Factories Act. Further, it would make it easier for the factory and public health departments to co-operate in an effective manner. The Government of Madras has recently instituted a three-weeks' course in public health for factory inspectors. While this is to be welcomed, the consensus of opinion among those who expressed their views on the subject was that the period of training should be at least three months.

### **The Zoning of Industry**

48. Industrial towns in India have grown up, in the past, in a haphazard manner and it is common to find factories in areas which are predominantly residential. The Madras Public Health Act and the Madras Town Planning Act have recognised the principles of zoning. Legislation in other provinces is not so definite and clear. We learnt from the Director of Public Health, Madras, that his Government has advised local bodies, through executive instructions, to set apart industrial areas and that installation of factories is normally permitted only in such areas. We were also informed by him that the policy of the Madras Government was to discourage local bodies from renewing the licenses of factories already existing in residential areas unless the motive power is electricity. The Madras Public Health Act provides that urban authorities should notify the residential areas within their territory in a period of one year and that no new factories or workshops or workplaces should be permitted to be established in them.

### **Administration of the Factories Act**

49. The Factories Act has given wide discretionary powers to chief inspectors and other inspectors of factories in the matter of instituting prosecutions in cases where there have been infringements of factory rules. In our opinion prosecution should, under such circumstances, be the rule and not an exception. The evidence given before us by inspectors and chief inspectors of factories is that courts are not inclined to impose heavy fines for offences under the Factories Act. While we are not in a position to verify those statements we must record our opinion that violations of the Factories Act and of the rules made under it should not be regarded leniently and that deterrent punishment is necessary in such cases.

### **Unregulated Factories**

50. The Factories Act defines a factory as meaning any premises where 20 or more employees are working or were working on any day of the preceding twelve months and in any part of which a manufacturing process is being carried on with the aid of power or is ordinarily so carried on. Section 5 of the Act gives power to Provincial Governments to make any of the provisions of the Factories Act applicable to factories in which the manufacturing process is being carried on, with or without the use of power,

whenever ten or more workers are working in it, or have worked therein on any day of the preceding twelve months. Further, these Governments have been authorised to apply, by certain amendments carried out in 1940 and 1941, some of the provisions of the Factories Act to small establishments employing less than ten persons, provided a child is employed on the premises and provided also that the establishment conforms in other respects to a small factory. Therefore Provincial Governments can, if they so desire, apply the Act to a large number of small establishments, whether they use motive power or not.

51. Our visits to small factories using power and without it in various parts of the country have convinced us that they require supervision and control. The conditions in the smaller establishments, particularly in the tanning and *bidi* industries and glass and bangle factories in Ferozabad in the United Provinces are indescribably bad. We have seen employees in these places working long hours in extremely unsatisfactory surroundings without the provision of such facilities as adequate light, air and drinking water. Children are freely employed in such establishments. We visited one in Sadar Bazaar in Delhi, where nearly 80 women were working with babies in their arms in a room with insufficient lighting and ventilation. The atmosphere was suffocating. In the same city we also visited the places in which tanners live and work in the Qarol Bagh area. The extent of filth and dirt in these places can hardly be described. Even small children were found working in these tanneries.

52. Some of the industries in which such conditions exist are of long standing and they fulfil a useful place in the economy of the country. They help men and women, who have family traditions in regard to certain trades, to earn a living in a country where the problem of existence is acute for very large sections of the population. The glass works in Moradabad, the silk handloom industry, Benares, and spinning and weaving establishments all over the United Provinces are valuable from an economic point of view and the Provincial Government has rightly followed the policy of encouraging them. We should be sorry if the effect of large scale industrialisation were to eliminate certain handicraft industries for which India has been noted in the past. While fully recognising this we are bound to stress that working and living conditions in many of these establishments require to be radically changed and that they should be brought under reasonable control. The question of devising such control will receive consideration when we put up our recommendations regarding industrial health in the next volume of the report:

## CHAPTER IX

### PERSONAL HEALTH SERVICES FOR CERTAIN DISEASES.

1. In India there exist all the diseases associated with temperate climates and, with a few exceptions, all those that are associated with the Tropics. For the purpose of this review we have, therefore, limited ourselves to the more important diseases prevalent in the country, which are given below. In dealing with each of them we shall first attempt to make an estimate of their incidence and then describe the measures, legal and administrative, that are in force for their control.

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| 1. Malaria.      | 7. Venereal diseases                       |
| 2. Tuberculosis. | 8. Hookworm disease.                       |
| 3. Smallpox      | 9. Filariasis.                             |
| 4. Cholera.      | 10. Guinea-worm disease.                   |
| 5. Plague.       | 11. Cancer.                                |
| 6. Leprosy.      | 12. Mental diseases and mental deficiency. |

Most of these are communicable diseases and, as there are certain common lines of action in respect of them, we shall briefly discuss them first.

2. The local bodies are responsible for health administration in their respective areas, including the control of epidemic diseases. The legal provisions defining their duties and powers in this connection are incorporated in the Self-government Acts which have brought these local authorities into existence. The powers conferred on them for the control of infectious diseases are, broadly speaking, larger in the case of municipal authorities than of rural local bodies. The provisions relate to the notification or the reporting of cases of infectious disease to the local health authority, the segregation and treatment of patients and the carrying out of other measures which are necessary for the prevention of the spread of infection. In addition to the powers contained in the Local Self-government Acts, an all-India enactment, the Epidemic Diseases Act, 1897, provides emergency powers to the different governments, Central and Provincial, in their respective areas of administration, for the promulgation of temporary regulations to deal with an outbreak or a threatened outbreak of infectious disease. Emergency regulations under this Act have generally been issued by Provincial Governments in the presence of widespread outbreaks of epidemics or in connection with certain festivals, which attract large numbers of pilgrims and are therefore associated with the threat of outbreaks of these diseases.

#### Notification

3. Municipal Acts generally provide that the householder or the medical practitioner, including the Hakim or Vaid attending on a patient, should report to the local authority the outbreak of infectious diseases. As regards the rural areas, in most provinces, the *chowkidar* or the village servant is responsible for reporting such events to the officer in charge of the *thana* or police station, who forwards the information to the local health authority. In the

province of Madras, however, the village headman is responsible for reporting epidemic diseases. In the rural areas the period elapsing between the outbreak of an infectious disease and its notification to a responsible public health official varies in the provinces, the delay being greater in those in which the *chowkidar* and the police department are responsible for this duty.

#### **Segregation and Treatment of Cases of Infectious Diseases**

4. In Chapter III of this volume we have already drawn attention to the fact that the existing number of infectious diseases hospitals in the country is small and that the conditions under which they are maintained are, generally speaking, quite unsatisfactory. The total number of permanent beds maintained in the whole country for the treatment of cases of infectious diseases is probably about 1,000, a provision which is far too small to deal with the segregation of the thousands of cases of cholera alone which occur in the country. Moreover, such infectious diseases hospitals as exist are located in the cities and larger towns and facilities for segregation are practically non-existent so far as the vast rural areas are concerned.

5. The provision of adequate isolation facilities to deal with the different infectious diseases prevalent in the country is, under existing conditions, an impossible task. During times of epidemics the number of patients requiring isolation in respect of any one of such diseases as malaria, cholera or smallpox is so large as to be well beyond the capacity of the local authorities concerned. In regard to tuberculosis and leprosy the prolonged period of isolation which is required and the possibility of a relapse into an infective stage, when the patient returns to active life, necessitate for the control of their spread, much more elaborate measures than those required for the common epidemic diseases. In the circumstances the practice of isolation in respect of any of these diseases is, broadly speaking, non-existent in the country as a whole.

#### **Other measures**

6. The existing health staffs, even in those provinces in which the public health organisation has been best developed, are quite insufficient to provide adequate service to the large populations entrusted to their charge. In the circumstances the control measures, which are undertaken, are of a limited nature. In the case of cholera, for instance, the action taken includes mass inoculation in order to confer protection against the disease on the affected communities and sterilisation of water supplies. In view of the inadequacy of staff and the large number of patients to deal with, often in widely separated houses particularly in the rural areas, disinfection of infective material can be carried out only in a perfunctory manner, the relatives of the patient being given disinfectants with simple instructions regarding the methods of carrying out sterilisation. Isolation and proper treatment of patients cannot be carried out for reasons which have already been given. As regards smallpox, the one measure that is undertaken is the vaccination of those who are exposed to risk.

## MALARIA

7. Malaria is by far the most important disease in all the tropical and subtropical countries of the world. The Malaria Commission of the League of Nations has estimated that 650 millions or about a third of the total population of the world suffer from this disease every year.

8. As regards India, the malaria problem was discussed at length in a health bulletin entitled "What Malaria costs India" which was prepared in 1935 by Lieut.-Colonel J. A. Sinton, a distinguished malariologist of international reputation and a former Director of the Malaria Institute of India.\* Major-General G. Covell, the present Director, has expressed the view that the position described in the bulletin remains true today. Colonel Sinton estimated that "at least 100 million individuals suffer from malaria every year in India". As attacks of malaria lead to a lowering of the resistance of the patient to other diseases, this disease is indirectly responsible for a rise in the morbidity due to other causes. Such indirect effects of malaria are said to be responsible for between 25 and 75 million cases of illness each year.

9. As regards mortality his estimates are equally impressive. Endemic malaria is believed to cause one million deaths in British India, while epidemic outbreaks of the disease may raise the figure by one-quarter to half a million deaths. Including the indirect effects of malaria in raising the general mortality rate in the community, Colonel Sinton thought that a rate of 8 per 1,000 of the population might not be an unreasonable estimate of the total deaths with which malaria would be associated as a cause. On the assumption that the population of British India is in the neighbourhood of 300 millions this rate gives an annual mortality of about 2,400,000 from malaria either directly or indirectly. This figure is about 37 per cent. of the average annual number of deaths in British India between 1932 and 1941.

10. These estimates are undoubtedly subject to a certain margin of error, but they were made by a distinguished malariologist with wide experience of Indian conditions and were based on a careful study of all the material available to him. While it may not be justifiable to accept these figures as precise statements of the incidence of the disease in India, they serve to establish beyond doubt that malaria is by far the most important health problem in the country. Measures directed towards controlling its incidence can confidently be expected to yield a richer harvest of improved health and general wellbeing than action taken against any other disease.

11. An unfortunate feature of the present malaria situation in the country is that, in many parts of the populated areas of India, man has been directly responsible for its incidence through creating conditions favouring the multiplication of the transmitting species of mosquito. For instance, embankments constructed in connection with roads and railways have, in many cases, interfered with natural drainage and have promoted water-logging. Burrow pits

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\* Its designation was in those days "The Malaria Survey of India".

are an accepted accompaniment of ordinary house-building operations and other engineering works. In more recent years projects designed to better the economic condition of large sections of the population have resulted in unnecessary addition to their misery. Irrigation projects, which bring water to previously dry areas, will produce malaria unless measures are taken simultaneously for adequate drainage to prevent the development of marshy conditions. The Sukkur Barrage and the Mettur Irrigation Project stand as object lessons of the result of failure to make such provision. In both cases malaria developed on a large scale in regions which were previously free from it. Nor is the ignorant villager free from blame in this respect. In and around the village site he makes and leaves uncovered, during house-building and other operations, pits which form pools and provide favourable conditions for the breeding of the malaria carrying mosquitoes.

12. Some idea of the geographical distribution of the disease in India and of its relative intensity of incidence may be obtained from the following extract from the 1939 Preliminary Annual Report of the Public Health Commissioner with the Government of India:—

“ Areas 5,000 feet above sea level are non-malarious and four widely separated regions, *viz.*, Eastern Bengal, the north-eastern portion of Brahmaputra Valley in Assam and two narrow strips of territory in Madras Presidency, in the Northern Circars and around Madras City, are relatively free from the disease, the spleen rate being under 10 per cent. The malarious tracts can be divided into five main types representing varying degrees of prevalence of the disease. The first consists mainly of the coastal regions of the maritime provinces of Bombay, Madras and Orissa, of wide areas in the Gangetic Valley, of the United Provinces and Bihar and of large tracts in the Central Provinces and the eastern portion of Central India. In these areas malaria is prevalent in a more or less static form of moderate to high intensity, fulminant epidemics being uncommon. Another type of malarious region exhibits the hyperendemicity associated with jungly hill tracts and *terai* land. These areas are widely scattered in the sub-Himalayan regions of the United Provinces and Bengal bordering on Nepal and Bhutan respectively, in Assam, the Chittagong Hill Tracts, the Central Provinces, the Chota Nagpur Hills and in the Western Ghats from a point well to the north of Bombay to the southern tip of the Indian peninsula. A third type consists of an extensive tract of dry area running across India from north to south and comprises Sind, Rajputana, the south-western portion of the United Provinces, a large part of Central India, Gujarat, Bombay, Deccan, Hyderabad and Mysore States and an area in Madras Presidency to the east and south-east of Mysore. This region is characterised by varying degrees of malarial endemicity depending on local factors such as irrigation. There is usually an autumnal rise in fever incidence and epidemics of malaria

may take place at intervals of a few years. To the north of this large area lies a territory consisting of a considerable part of the Punjab, Delhi Province and the north-western portion of the United Provinces, the boundary running well to the east of Agra and Bareilly. This region is liable to outbreaks of fulminant epidemic malaria, the spleen rate being high during and immediately after such epidemics and slowly falling to a low rate in the course of five or six years. A fifth type, showing hyperendemicity unassociated with hilly conditions exists in strictly localised areas, for example, the Tanjore district of Madras Presidency, a thin coastal strip above Madras City and isolated spots in Orissa and Bengal."

13. In a review of the action taken by the authorities to control the incidence of malaria it must be frankly stated that the efforts so far made have been quite inadequate to make even a faint impression on the incidence of the disease in the country as a whole. This is partly due to the fact that, in the provinces, a sufficiently large organisation to deal with the problem of malaria control in an effective manner has not yet been established. Further, provision for the treatment of the many millions of cases occurring every year has also been quite insufficient. During the period to which our review relates quinine was the only drug widely in use in the country. The total annual consumption of this drug in India was about 210,000 pounds while, if Lieut.-Colonel Sinton's estimate of at least 100 million individuals suffering from malaria every year is even approximately correct, sufficient quinine should be available, in view of the relapses that occur, for the treatment of at least 150 million cases per year. At the rate of 75 grains per patient, which has been suggested by the Malaria Commission of the League of Nations as the minimum amount required for treatment, India will require about 1.6 million pounds of the drug every year or nearly eight times the quantity actually used in the country. It should be mentioned that, even if this very large amount of quinine became available, the existing health organisations would not have been able to distribute the drug in the affected areas. In the four or five years just preceding the outbreak of the war in 1939, the Government of India gave a few thousands of pounds of quinine to Provincial Governments for enabling them to distribute the drug, free of cost, in the malarious areas within their territories. It is understood that even the distribution of this relatively small amount, which was spread over a few years, could not be carried out satisfactorily because of the difficulty of securing suitable staff for doing it.

14. We shall now describe briefly the antimalaria activities carried out under the auspices of the Central and Provincial Governments.

### **The Centre**

15. Central funds have been expended, for sometime past, on the establishment and maintenance of an all-India organisation for the study of malaria problems and for assisting the provinces with

technical advice in regard to this subject. Starting first as the Central Malaria Bureau and the Entomology Section of the Central Research Institute, Kasauli, the organisation was made, in 1926, a separate institution under the Indian Research Fund Association, which is almost wholly financed by the Government of India and designated the Malaria Survey of India. Later the name was changed to the Malaria Institute of India. It was first designed to undertake teaching and research in the subject but it soon began to be called upon to take up public health work on an increasing scale and to assist Provincial Governments in the investigation of their malaria problems and in the formulation of the necessary control measures. The Government of India took over, in 1940, that part of the Institute which was engaged in duties of this kind while the research activities of the organisation have continued to be financed by the Indian Research Fund Association.

16. The functions of this Institute are the following:—to be fully informed of all malaria problems so as to be able to advise the Central Government on all issues relative to malaria in India, to initiate enquiries and investigations on malaria; to assist provincial organisations in the carrying out of such enquiries as they may undertake and to lend officers temporarily from the staff to work on such enquiries; to undertake systematic research underlying malaria transmission, prevalence and prevention and to arrange for such knowledge to be made available for practical application; to advise upon and assist in the carrying out of antimalaria measures and to undertake clinical work on malaria including treatment; to assist all affiliated researches, *e.g.*, kala-azar, filariasis, sandfly fever, dengue and work on yellow fever carrying mosquitoes of the *stegomyia* group; to train staff in practical malaria work and to publish scientific articles, bulletins, etc., in the appropriate journals. The staff to carry out these extensive duties consisted, in the prewar years, of a Director, two Assistant Directors, an Entomologist and certain subordinate technical assistants. In the postwar period the Institute will have to expand its activities considerably in the fields of training personnel, of research and of technical assistance to the provinces if the campaign against the disease is to be developed on an effective scale. The need for a suitable expansion of the existing organisation will, therefore, have to be considered in putting forward our proposals for dealing with malaria.

17. During the period of its existence this central malaria organisation has taken a prominent part in the training of anti-malaria personnel. Between 1910 and 1938 over 460 civil medical officers were trained, although for a period of about 10 years from 1914 to 1924 the course was suspended owing to the outbreak of the first World War and its after effects. During the present war the need for antimalaria personnel became increasingly urgent with the spread of operations to the Far East and between 1941 and 1945, 24 intensive courses were held which were attended by officers of the Army, Air Force and Navy as well as by a few members of the forces belonging to the Governments of the United States and



China. A certain number of science graduates was also trained as antimalaria assistants. The total number of medical officers and antimalaria assistants thus trained during this period of four years was 630. In addition 426 members of the Indian Hospital Corps and sanitary inspectors received training during the same period. During 1940-41 three courses in malariology were organised for engineers which were attended by 87 officers.

### **The Provinces**

18. A striking feature of the efforts made in the past is that they have been, speaking generally, of a spasmodic character. In this connection we may mention that our attention was specially drawn by the Director of the Malaria Institute of India to such discontinuity of effort on the part of local authorities. He quoted instances where such authorities had commenced antimalaria operations in pursuance of advice given by the Institute after an investigation of the local malaria problem and where a lowering of the incidence of the disease has been brought about as the result of such measures. A common sequence of this is a reduction of the antimalaria staff in order to cut down expenditure, followed, in the course of a few years, by a recrudescence of the disease on a large scale.

19. Health administrations seem to have hardly realised the fact that the battle against malaria should not cease with the temporary disappearance of the enemy and that continued operations conducted with adequate staff, working under proper technical provision, are essential if lasting results are to be obtained. Even permanent works for the control of the disease require maintenance while recurrent measures are to be viewed in the same manner as other public health measures such as the cleansing of streets and the purification of water supplies. Every kind of control measure, no matter how simple it may be, requires adequate supervision.

20. Continuity of effort can only be attained if sufficient salaries are provided for the staff so that they may be content to remain in their posts and not be continually on the lookout for more lucrative employment. It is particularly important that labourers employed on antimalaria work should receive a wage at least as high as that paid to any other field workers in the same area. Many of their activities require a considerable degree of technical skill. This is particularly the case in the application of the more modern methods of malaria control namely the spray-killing of mosquitoes with D.D.T. and similar insecticides. Antimalaria labourers should be classed as semi-skilled, and should be designated as field workers rather than coolies.

21. We have already said that antimalaria organisations have not so far been developed in the provinces on a sufficiently large scale to deal with their malaria problems. At the same time it may be mentioned that, in certain provinces, small malaria organisations exist around which expanded services can be built up in order to meet the requirements of the populations concerned. These organisations are now carrying out antimalaria operations in limited

areas, malaria surveys in selected places and the training of lower types of malaria personnel. Some of these provincial establishments and their activities are described below:—

22. *Bombay*.—The organisation in this province was created on a permanent basis in 1942 on the advice of the Director, Malaria Institute of India. It consists of an Assistant Director of Public Health (Malariology), an Entomologist, six antimalaria medical officers and a team of laboratory and field assistants specially trained in antimalaria duties. For the first three years of its existence, the activities of the organisation were mainly investigatory. It is now proposed to take up malaria control on a comprehensive scale over the whole of North Kanara and part of Dharwar Districts, involving 6,000 square miles of country with a population of over a million.

23. *Madras*.—Two special investigation and control units exist each under the charge of a first class Health Officer and with entomological and field staff attached to it. These units are working at Pattukottai in Tanjore District, and in the area of the Thungabhadra irrigation project respectively. A field station with a first class Health Officer is associated with a land colonisation scheme at Wynaad, Malabar District and is working in liaison with the Agricultural and other Departments. Eight other field stations exist in the province, the more important among which being at Ennore near Madras, at Harur in Salem District, and at Krishnadevipet and Tekkali in Vizagapatam District. A Malaria Officer attached to the office of the Director of Public Health is in direct charge of these field stations, and he also coordinates the entire malaria work in the province. For this purpose, he has two investigation units which may be sent out to the districts. Special investigations are also in progress, such as research work on vegetable oils as substitutes for mineral oils, and investigation of naturalistic control measures by the cultivation of fallow fields with green manure crops prior to transplanting. Other activities include the cultivation of pyrethrum on an extensive scale in the Nilgiris and the Palni Hills, the extraction of pyrethrum in a special plant at the Government Soap Factory at Calicut, and the training of sanitary inspectors, laboratory and field Assistants at Krishnadevipet Malaria Field Station, Vizagapatam District. The last, the oldest field station in the province has been in existence since 1927 and is in charge of an Assistant Malaria Officer. It has several field out-stations in the hyperendemic Agency tracts close by and is well equipped for training laboratory and field Assistants. During the last three years, the station has trained over two hundred such personnel besides giving short refresher courses to sanitary inspectors and health officers. The construction of a permanent building to house the station and its equipment on an adequate scale are under active execution.

24. *The United Provinces*.—The malaria organisation is under the control of an Assistant Director of Public Health (Malariology). Control measures are mainly the responsibility of local health authorities and, besides the usual lack of funds, there is at present a

considerable shortage of antimalaria requisites. Some malaria control measures are being attempted by administrative action, such as stoppage of wet cultivation within a certain distance of the towns, regulation of the amount of water to be supplied for irrigation in certain areas and the enforcement of conditions, subject to which alone water would be supplied, *e.g.*, keeping the water courses leading to the fields clear of rank vegetation. All drainage schemes prepared by local bodies which receive grants from the provincial funds are scrutinised by the Public Health Department as to the possible effect on the incidence of malaria in the area concerned. Orders have been issued recently by the Provincial Government for scrutiny by the Director of Public Health of all major irrigation projects. In order to determine the adverse effect they may have on the incidence of malaria in the area concerned, joint antimalaria committees to represent the military, railway and civil departments have been established in places where such co-operation is necessary for the formulation of antimalaria measures and their execution.

25. *The Punjab.*—Antimalaria operations in the province are under the control of the Punjab Epidemiological Bureau which is in charge of an Assistant Director of Public Health. He is assisted by two Assistant Epidemiologists. There is also a Field Epidemiological Unit which is comprised of a qualified entomologist, two sub-assistant health officers and suitable subordinate staff. This Unit is primarily employed for investigations in connection with malaria and for carrying out malaria control operations, on special occasions, in different parts of the province. In addition 19 officers of the Public Health Department have so far received training in malariology at the Malaria Institute of India or abroad. The medical officers of health, sanitary inspectors and certain other individuals in the service of local bodies are also given, from time to time, short courses in malariology at the Epidemiological Bureau. The latter undertakes a bi-annual spleen census of school children under ten years of age in the province during the months of June and November and, basing partly on these results, prepares a preliminary and final malaria forecast in the month of September every year regarding the probable incidence of malaria in the ensuing autumn.

26. *Delhi Province.*—In the urban areas of this province anti-malaria measures have been developed on a large scale during the past six or seven years under the technical direction of the Malaria Institute of India. These measures have included engineering works designed to control the breeding of mosquitoes as well as the active spray-killing of adult mosquitoes during the malaria season through the use of pyrethrum and, lately, of D.D.T. The past few years proved to be a severe testing time for the Delhi antimalaria organisation owing to various factors favouring the spread of the disease, which were largely the result of conditions arising out of the war. The organisation can, broadly speaking, be said to have stood the test in that the epidemic outbreak of malaria, particularly in 1942, which was the year of the largest

incidence, was not permitted to assume the proportions which previous experience, in the years before control operations started, had shown as possible in the Delhi area.

27. The brief descriptions given above of the antimalaria measures carried on in a number of provinces are sufficient, it is hoped, to indicate the total inadequacy of the existing organisations and the work done by them to make an impression of the incidence of the disease in the country as a whole. Before completing the story it must also be mentioned that provincial authorities have been carrying out the free distribution of quinine, and more recently of mepacrine, to the affected populations in their respective territories on as wide a scale as the availability of the drugs and of personnel for their distribution permit. From what has been said earlier in this chapter, it will be seen that only a small section of the affected population could have been reached by such distribution.

### TUBERCULOSIS.

#### **The Importance of Tuberculosis as a Public Health Problem in India**

28. Tuberculosis ranks high as a public health problem in India. In his annual report for 1933 the Public Health Commissioner stated that "Tuberculosis is now almost certainly one of the main public health problems in India, ranking probably next to malaria in this respect. In fact, it may be regarded as an epidemic disease". No accurate estimate of the incidence of the disease or of the average annual number of deaths resulting from it can be made. In his annual report for 1935 the Public Health Commissioner suggested that a rough estimate of tuberculosis mortality might be made on the assumption that about 10-20 per cent. of the deaths under "fevers" and about 20 per cent. of those under "respiratory diseases" were actually due to pulmonary tuberculosis. The average annual number of deaths from "fevers" recorded in British India (excluding Burma) during the decennium 1932-41 was 3,622,869 and of "respiratory diseases" 471,802. Using these figures, the average number of deaths per year from pulmonary tuberculosis in British India will range between 456,647 and 818,934.

29. In a memorandum submitted to us Dr. P. V. Benjamin, Medical Superintendent, Union Mission Tuberculosis Sanatorium, Arogyavaram, S. India, expressed his views on tuberculosis mortality and on the prevalence of the disease in the following words:—

"Mortality figures for cities show a tuberculosis death rate of from 200 to 450 per 100,000 as far as can be ascertained. Little information is available from rural areas, but certain investigations have shown that in small up-country towns the infection rate is nearly as high as in the larger cities, and that in the villages it is lower but still considerable. It can be safely estimated that there are at least 500,000 deaths from tuberculosis annually in the whole of India, and if the general European standard of about 5 cases of active tuberculosis to one tuberculosis death is accepted, there will be at least 2,500,000 active cases of tuberculosis in India."

It will be seen that these estimates are no more than expressions of personal opinion by certain individuals. Even so they are not without value as they help to focus attention on the magnitude of the problem from the point of view of providing adequate medical relief and of instituting the required preventive measures.

### **The Characteristics of Tuberculosis as a Community Disease**

30. The main features of tuberculosis as a community problem are well known. Its incidence is rare among people who lead an open air life and among those who live in small communities, but it increases in proportion to the degree of overcrowding. Close contact with patients in badly ventilated dwellings helps the development of the disease. Children are particularly susceptible to infection and observations by numerous investigators have shown that, in families with one or more patients discharging the tubercle bacillus in their sputum, the children have a much higher rate of mortality from tuberculosis than among children in families with sputum-negative patients.

31. Among other factors contributing to the spread of the disease may be mentioned malnutrition and undernutrition, unhygienic housing and environmental conditions and certain occupations, particularly those associated with the inhalation of dust containing fine particle of silica.

32. No age, sex or race is exempt from tuberculosis. In countries where the disease has been prevalent for a long time susceptibility to infection is highest among infants and a varying measure of protection becomes developed as the years go by, through small doses of infection being picked up by most individuals. It is stated that, in the industrial cities of Europe and America, a large majority of the children become infected with tuberculosis by the time they reach 18 years of age. Only a small proportion of those who take up infection develop the disease or die of it, while the majority acquire a considerable degree of protection against it. On the other hand in communities exposed to tuberculosis for the first time, *e.g.*, primitive races coming in contact with persons from the highly tuberculised countries, the disease occurs in a virulent form and the rate of its spread is rapid. In countries with a long history of tuberculosis infection, it is only among infants that conditions exist which approximate to those of the highly susceptible communities.

33. One more point may be referred to when considering the disease in its epidemiological aspects. There are three types of the organism which can produce disease in man. They are the human, bovine and avian types, the names indicating the species to which each type has become habituated. Of these, infection of human beings by the avian type is relatively rare. On the other hand, in countries where tuberculosis is common among cattle, human infection by the bovine type is not infrequent. It is said that, in England, about 40 per cent. of all milch cows give evidence of having been infected with tuberculosis at some time or other, about 40 per cent. of the cattle slaughtered in public abattoirs show

visible signs of tuberculosis and about 0·5 per cent. of the cows are actually excreting tubercle bacilli in milk.\* Infection by the bovine type is caused by the ingestion of the unboiled milk or imperfectly cooked meat of infected animals. In England and Wales about 6·0 per cent. of all deaths from tuberculosis are due to infection of bovine origin.

### **Tuberculosis Surveys in India**

34. We have described, at some length, the salient features of the epidemiology of the disease because these fundamental facts must be borne in mind when considering the question of investigating the extent of prevalence of the disease in the country and of promoting measures for its control.

35. The purpose of a properly conducted tuberculosis survey is to provide information on such matters as the extent of tuberculosis infection in the community concerned and the incidence of the disease in relation to age, sex and various associated factors, including environmental hygiene and nutrition. A special sub-committee appointed by the Indian Research Fund Association has prepared a memorandum embodying detailed instructions for the carrying out of tuberculosis surveys and this memorandum should form the basis for all future surveys undertaken in this field. The studies so far carried out in India have not all been on the lines indicated in the memorandum. However, a brief review of the findings of these investigations is made below:—

36. The first survey of tuberculosis in India appears to have been made by Dr. Arthur Lankester, whose report was published in 1920. The investigation was undertaken under the auspices of the Indian Research Fund Association and occupied a period of two years from July 1914 to June 1916. In the absence of reliable statistics, he had to base his opinion mainly on evidence given by medical officers and administrators in different parts of the country. The conclusion he reached was that the incidence of the disease was steadily increasing. He summed up the position in the following words:—

“The impression left upon the mind after careful inquiry, with comparison of such statistics as are available, is that many large areas in India, which 40 years ago were practically “virgin soil” to tuberculosis, have now become to a considerable extent infected; that phthisis has been for generations, probably centuries, a common disease of the larger cities, yet even in these there has been considerable actual increase during the last 40 years; that while in smaller towns and in the village districts it was formerly comparatively rare or even absent, yet in these during a similar period the disease has made its appearance and spread widely. The increase has been most marked in connection with those centres which have shown the greatest commercial and educational development, and in the village districts which have been linked up with them by direct lines of communications.”

\* The Principles of Bacteriology and Immunology by Topley and Wilson.

37. Surveys in limited areas have been carried out in different parts of the country during the succeeding years. The results may be considered from the two standpoints of—

- (1) the incidence of tuberculosis infection as demonstrated by certain skin tests, such as von Pirquet and Mantoux tests, and
- (2) the presence of tuberculous disease.

A survey of the incidence of tuberculous disease was carried out in a small part of Lahore city in 1933. This survey did not include an investigation of tuberculosis infection by skin tests. Of a total number of 8,269 individuals examined, 311 showed signs of tuberculous disease giving a morbidity rate of 3·8 per cent.

38. In an investigation carried out in a population of 6,665 unselected persons in certain villages and small towns in Chittoor District of Madras Presidency by Dr. P. V. Benjamin in 1938, the following results were obtained. In small towns 40·1 per cent. of the adults and 11·6 per cent. of children under 15 years gave evidence of tuberculosis infection as judged by the skin tests. In the villages the corresponding percentages were 30·8 for adults and 8·2 for children.

39. In 1939 a similar investigation carried out in a large town (Saidapet in Madras Presidency) revealed an infection rate of 69·81 per cent. for adults and 41·2 per cent. for children under 15. Dr. Benjamin and his co-workers pointed out that, apart from the high rate of infection in the community as a whole, which these figures indicated, the rate among children in Saidapet was appreciably higher than the corresponding figures for children which certain investigations in the United States of America and England had disclosed. In 1930 an enquiry conducted by Chadwick and Zacks among 101,118 children under 15 years (mostly living in towns) in Massachusetts gave a percentage of 28 for Mantoux positives and a study by Dow and Lloyd in 1931 of tuberculosis infection among 1,220 children, partly contacts of tuberculous parents in London, gave the percentage as 27·2.

40. Among 3,307 persons examined in Saidapet during this investigation 87 persons were found to be suffering from active disease (2·6 per cent.) and requiring immediate treatment. A significant fact in respect of a number of them was that they were going about their daily duties without knowing that they were sick. Some of them were even excreting the tubercle bacillus. It is stated that, among such open cases, one was a bus conductor, one a clerk in a shop, another a student attending college and yet another the watchman of a public rest house.

41. Dr. A. C. Ukil, who has for many years been actively engaged in the study of the tuberculosis problem, has stated that "In predominantly agricultural countries like India, the infection rate varies from 21 to 34 per cent. in rural to 80 to 90 per cent. in urban and industrial areas". As regards the incidence of the

disease, he has summed up his views in respect of Bengal, to which his work has been mainly confined, in the following words:—

“ From the very few properly conducted surveys in India the disease rate of pulmonary tuberculosis in urban areas (Bengal) appears to be 7 per cent., among workers in industrial areas (Bengal) to be 4 per cent. and in rural areas (Bengal) to be 0·6 per cent. among selected samples of the population. More surveys are needed to assess the correct position with regard to morbidity in different parts of the country. The morbidity rate for pulmonary tuberculosis in tubercular homes in certain localities in Calcutta has been found to be 18 per cent. among children below 15 years.”

42. In 1941 a tuberculosis survey was carried out in Sialkot by Dr. C. L. Sahni, the Medical Officer of Health of that town. The survey was limited to boy and girl students up to the age of 18. Of a total of 3,455 boys examined by the Mantoux test, 28·8 per cent. showed a positive reaction. An analysis of the figures by ages showed that the highest percentage of positives (41·6) was recorded in the age period 16-17 and the lowest (12·5) in the age period 5-6. Generally speaking, the percentage rose steadily from the lowest age period, 5-6, through the succeeding years of life. A total of 2,981 girls was examined and of them 39·2 per cent. showed positive reaction, the highest percentage (56·8) being recorded in the age period, 15-16, and the lowest at 6-7. Among the girls also there was, generally speaking, a steady increase in the percentage of positives along with a rise in age.

This investigation did not include an enquiry into the prevalence of tuberculosis disease.

43. From this brief review it will be seen that the incidence of tuberculosis (infection and disease) varies from place to place. There is reason to believe that the susceptibility to tuberculosis differs among various communities. Dr. Ukil considers that “ as regards the resistance factor *vis-a-vis* tuberculosis, China and India seem to occupy an intermediate position between the virgin African and the Western European races.....Tuberculosis infection, though increasing in recent years owing to the increasing urbanisation, industrialisation and the introduction of rapid transport facilities, is not yet so widespread as in Europe and America.”

44. The view that tuberculosis infection in India is not at present so widespread as in Europe and America should not, however, lead to an attitude of complacency. The death rates from tuberculosis in some of the important cities in India already exceed the corresponding rates in well-known cities abroad. The following figures are quoted from an editorial entitled “ Tuberculosis as a public health problem in India ” in the 1941 October issue of the Indian Medical Gazette.

*Tuberculosis deaths per 100,000 population.*

Paris . . . .	177	Cawnpore . . . .	432
Mexico . . . .	170	Lucknow . . . .	419
New York . . . .	128	Madras . . . .	290
Berlin . . . .	120	Calcutta . . . .	230
London . . . .	96	Bombay . . . .	140



45. The increasing urbanisation and industrialisation that the post-war years may be expected to promote in India will lead, unless prompt measures are taken, to a further spread of the disease in the country and to an increase in its incidence in the towns and cities. The continuous exchange of population that takes place between industrial centres and the rural areas is another potent factor for hastening the pace at which infection may spread.

46. The significant part that the bovine type of organism plays in the epidemiology of tuberculosis in certain countries has already been referred to. As regards India, the bovine organism is of much less importance. In his book entitled "Tuberculosis in India" Dr. Lankester brought together a considerable volume of evidence suggesting the comparative rarity of tuberculosis infection among the cattle in India and summed up his views in the following words:—

"In conclusion, there seems to be ample evidence to justify the deliberate opinion that in India, bovine tuberculosis does not at present call for serious consideration as an important cause of the human disease, and that measures taken with a view to the improvement of the milk supply should be directed towards the prevention of contamination *after* it has been drawn, rather than towards the elimination of tuberculosis from the cow."

Although more recent work has indicated that tuberculosis infection may be present in cattle housed under congested conditions in towns, its incidence continues to be small and the cattle living under open air conditions in the rural areas are free. Another factor for safety is that milk is drunk in this country after boiling.

47. The subject may also be discussed from another angle. Dr. Ukil has isolated and studied different strains of tubercle bacillus from a wide variety of pathological material from patients, such as bones and joints (tubercular abscess), cervical, axillary, inguinal and other glands, lung tissue, pleural fluid, sputum, etc. In all 254 strains have been studied and all the strains have been shown to belong to the human type. All the evidence available seems therefore to suggest that, at present, the bovine type of the organism is of no importance in the causation of human tuberculosis in India. There is, however, need for vigilance. There is the possibility of the spread of the disease among cattle from existing infected animals, although they may be few in number. Imported cattle may also prove to be a source of danger.

48. To sum up, it is not possible to estimate with any reasonable degree of accuracy the incidence of tuberculosis infection and of disease in the country as a whole or in different parts of it. There is reason to believe that its incidence is higher in urban than in rural areas and that, in both types of areas, infection is spreading and active cases of tuberculosis are increasing. The growth of towns and cities, the development of transport facilities and industrialisation are contributory factors to this increase and there is therefore the possibility that their adverse effect may be even more pronounced in the coming years.

49. In limited areas the infection rate disclosed by surveys (*e.g.*, Saidapet) reveals a state of affairs in no way better than that associated with such definitely tuberculised countries as England and the United States of America. The part that contact with tuberculous patients plays in the spread of the disease and the vulnerability of children in particular have also been brought out by the limited studies carried out in the country.

#### **Increasing Interest in the Tuberculosis Problem**

50. The tuberculosis problem has of recent years received increasing attention at the hands of the authorities and of the public. Even so the organisation of a campaign against it on proper lines and in adequate proportion has not yet been attempted or even formulated. The reason is not far to seek. A social disease such as tuberculosis can be combated successfully only if ameliorative measures on an extensive scale can be undertaken so as to improve the general standard of living, including housing, nutrition and the sanitation of the environment in the home, the workplace, and places of public resort. An organised effort for improving environmental hygiene has hardly begun, partly because of the high cost involved and partly because the people have not been educated to recognise the need for, and demand the provision of, such improved conditions of life. Secondly the importance of tuberculosis as a public health problem has begun to receive attention only within the past decade or two. As has already been pointed out the first report of a survey of the prevalence of the disease, which was carried out by Dr. Lankester, was published only in 1920 and the brief summary of the subsequent investigations carried out in different parts of the country, which has been given in previous paragraphs, indicates how limited and fragmentary is the information that is available regarding the extent and degree of its prevalence. These pioneering efforts have, however, had the salutary effect of bringing before the authorities and the public the magnitude and urgency of the problem. A third reason is that the existing public health organisations in the provinces, which are still in a relatively early stage of development, have found their time fully occupied with the measures necessary for such epidemic diseases as smallpox, cholera and plague. Moreover, such funds as Provincial Governments are able to spare for the development of health services are altogether inadequate to meet the large expenditure that a modern tuberculosis organisation requires to cover its manifold activities, including preventive care of the patients and their contacts in the home and provision for institutional treatment and aftercare.

51. The awakening of the public mind to the importance of the tuberculosis problem has borne fruit in the organisation of voluntary effort for antituberculosis work and the lines on which two voluntary bodies engaged in this work are functioning are of particular interest in this connection. These organisations are the Tuberculosis Association of India and the Bengal Tuberculosis Association and a brief review of their activities is given below.

### **The Tuberculosis Association of India**

52. The desirability of establishing an All-India association for antituberculosis work and of promoting closer cooperation between Government and voluntary agencies engaged in the campaign against the disease was emphasised by Dr. Lankester as the result of his survey of its incidence in India. This suggestion was implemented in 1929 when it was decided that the funds raised by public subscription to commemorate the recovery from illness of the late King George V during the winter of 1928-29 should be devoted to the promotion of antituberculosis work in the country and the King George V Thanksgiving Antituberculosis Committee was formed. The organisation consisted of a Central Committee at New Delhi and of branch Committees in the Provinces and States. It had only an annual income of Rs. 53,000 and its activities were, therefore, of a limited nature. The Central Committee appointed an Organising Secretary who toured the Provinces and States and organised local branches, addressed public meetings and helped to focus attention on the tuberculosis problem.. Its other activities included the organisation of special training courses in tuberculosis for medical men at the All-India Institute of Hygiene and Public Health and at a number of provincial centres as well as the preparation of propaganda material for distribution to the provincial branches.

53. The next stage in the organisation of tuberculosis work on an All-India basis was reached when an appeal was made by Her Excellency the Marchioness of Linlithgow in December 1937 in the name of the King Emperor. This appeal, which met with an excellent response from the people and Princes of India, made it possible to organise the campaign on a broader basis and the Tuberculosis Association of India was formed in February 1939. The King George V Thanksgiving Antituberculosis Fund was merged in the funds of the Tuberculosis Association of India.

54. The Association has a Central Committee in New Delhi and Provincial and State Associations, which are all independent bodies governed by their individual constitutions. The central organisation functions as the agency for giving expert advice and for coordinating the activities of the Provincial and State Associations. Standardisation of methods, the promotion of consultation by conferences, the training of various types of tuberculosis workers, the stimulation of research and education of the public in antituberculosis measures are among its main functions. Other activities, such as the establishment of hospitals and clinics, are considered the responsibility of Provincial and State organisations. Only five per cent. of the total money collected was handed over to the Central Association and 95 per cent. of the amount subscribed in each Province or State was given to the local Association.

55. The outbreak of war, which followed soon after the establishment of the Tuberculosis Association of India, crippled to some extent the activities of the organisation. The Association has,

however, attempted to do what was possible to achieve within the limits set by the war. One of the first steps taken by the Association was the appointment of Dr. Frimodt Moller as its Medical Commissioner in May 1939. His wide experience of the tuberculosis problem in India and the personal contacts he made with other workers and administrators during his tours as Medical Commissioner were of great help to the Association in organising its policy on sound lines from the beginning. Three major measures are associated with his tenure of office. They are:—

- (1) the establishment of the tuberculosis clinic in New Delhi,
- (2) the creation of the Lady Linlithgow Sanatorium at Kasauli and
- (3) the formulation of a scheme for organising home treatment as an essential part of antituberculosis campaign in this country.

56. A scheme for treatment in the home has been working in Delhi for the past few years and it will be discussed in greater detail later. Suffice it to say here that India has altogether a little over 6,000 beds for tuberculosis patients. In countries where anti-tuberculosis work has been organised on sound lines, the number of beds required is estimated on the basis of the annual mortality from the disease. The ratio in respect of such countries ranges between three beds to one death and one bed to one death. If Dr. Benjamin's estimate of 500,000 as the average annual number of deaths from tuberculosis in India is accepted, the disparity between the existing provision for institutional treatment and what should be considered as desirable becomes unmistakably clear. In the circumstances some form of home treatment seems to be essential for meeting the situation.

57. Other activities of the Tuberculosis Association of India were the holding of two conferences of tuberculosis workers at New Delhi in the month of November in 1939 and 1940 and the organisation of facilities for the training of tuberculosis workers, namely, doctors and health visitors.

### **The Bengal Tuberculosis Association**

58. The Bengal Tuberculosis Association is another voluntary organisation which has done much to develop antituberculosis work on sound lines in that province. It was established in 1929. The Association maintains seven dispensaries in Calcutta and Howrah areas, the Chest Department of the Medical College Hospital being the largest of these. A number of dispensaries was also gradually opened in the mofussil. In 1943 eight such dispensaries were functioning at widely separated centres, such as Serampore, Budge Budge, Krishnagar, Barisal, Berhampur, Darjeeling, Kalimpong and Comilla.

59. The work done by the Association within the period, 1929 to 1943, is summarised in tabular form below:—

(1) No. of patients examined at the dispensaries of the Association . . . . .	704,683
(2) No. of tuberculous patients . . . . .	41,039
(3) No. of cases of pulmonary tuberculosis among the patients in (2) above . . . . .	38,365
(4) No. of visits to the homes of tuberculous patients by health visitors . . . . .	327,607
(5) No. of contacts traced . . . . .	47,651
(6) No. of contacts examined with tuberculin tests and X-ray . . . . .	15,530
(7) Percentage of contacts showing signs of active pulmonary tuberculosis . . . . .	25.02

Of the total number of patients examined at the dispensaries maintained by the Association about 5.8 per cent. were suffering from tuberculosis. A striking feature is that, of the total number of tuberculous patients, 93.5 per cent. had pulmonary tuberculosis. The lung seems therefore to be pre-eminent the organ attacked by the tubercle bacillus.

60. The importance of examining the contacts of patients is clearly brought out by the fact that, of 15,530 such persons, about 25.02 per cent. suffered from pulmonary tuberculosis.

61. The Association trained, during the period under consideration, 102 Health Visitors for antituberculosis work, including 30 candidates from other provinces. It has helped in the training in tuberculosis of the students of the Sir John Anderson Health School (health visitors) and has also taken part in the training courses held in Calcutta for doctors from all parts of India under the auspices of the Tuberculosis Association of India.

62. Since 1933 the Association has received an annual grant of Rs. 10,000 from the Government of Bengal. In addition, the Provincial Government has recently sanctioned a scheme for extending antituberculosis work in the Province with which the Association will be connected. A grant of Rs. 3,000 will be given by Government in each case towards the capital cost of establishing a clinic attached to such sadar and sub-divisional hospitals as are equipped with X-ray facilities. Each clinic is estimated to cost, for its establishment, about Rs. 6,000 at prewar rates and the balance of Rs. 3,000 is expected to be raised by the local committee of the Association which will exercise general supervision over these clinics in so far as the preventive side of the campaign is concerned. Two Tuberculosis Health Visitors will be attached to each clinic, one of them being paid by the Association and the other by Government. The latter have also recently appointed two Tuberculosis Officers to help in the organisation of the proposed antituberculosis campaign.

63. The income derived by the Association from the interest of the King Emperor's Antituberculosis Fund is stated to meet barely half the annual recurring cost of its present activities in Bengal. It is clearly beyond the financial and organisational capacity of a voluntary association to tackle the problem of tuberculosis on

adequate lines. But the work that has so far been accomplished within the past 15 years has undoubtedly helped to focus the attention of Government and of the public on the urgent need for anti-tuberculosis work.

### **Organised Home Treatment in Delhi**

64. The following remarks on the scheme of organised home-treatment in Delhi are based on a note received from Dr. B. K. Sikand, Medical Superintendent, New Delhi Tuberculosis Clinic, who has been closely associated with the working of the scheme.

65. In 1941 the Government of India sanctioned an annual grant of Rs. 8,000 to the Provincial Tuberculosis Association of Delhi for inaugurating an experimental scheme of organised home treatment. The institutions associated with the working of the scheme are the New Delhi Tuberculosis Clinic maintained by the Tuberculosis Association of India, a clinic maintained by the Delhi Municipality and the Ramakrishna Mission Tuberculosis Clinic. The scheme is in operation in a certain number of wards of Delhi city. In the beginning the scheme was introduced in two wards, namely, ward Nos. 10 and 13, the first being placed under the New Delhi Tuberculosis Clinic and the other under the Delhi City Municipal Clinic. In 1942 the scheme was further extended so as to bring ward No. 8 under the New Delhi Tuberculosis Clinic, ward No. 12 under the Municipal Clinic and ward No. 11 under the Ramakrishna Mission Clinic. The grant available for each ward is about Rs. 1,500 per year. The total population of all these wards is 150,000 or approximately 30,000 for each ward.

66. Excepting for minor details the scheme of work is the same. Tuberculosis patients from the areas where the organised home-treatment scheme is in operation are kept under observation and are treated at the clinics assigned to each of these areas.

67. All patients requiring medical care come to the clinic once a month and they also receive a monthly visit in their homes by a doctor on behalf of the clinic. In a very limited number of cases the visits to patients may be more frequent, *e.g.*, cases requiring injections for treatment receive two visits a week. Besides giving treatment the doctor interests himself in the preventive aspect of tuberculosis work, encourages the contacts of patients to come to the clinic for examination, offers advice for the removal of unhygienic conditions in the patients' homes, studies the social and economic difficulties of the home and offers suggestions to the clinics as to how best to meet them in individual cases and supervises the preventive work done by the health visitors. The latter pay frequent visits to the homes of patients in order to advise them and their relatives on preventive measures.

68. A Care and Aftercare Committee has been established in each area, its function being mainly that of raising funds to provide relief to the poorer patients and of keeping contact between the clinic, patients and general practitioners.

69. It is stated that the scheme has not in actual working attained unqualified success. Unfortunately, the starting of the

scheme synchronised with the difficult conditions arising out of the war, which rendered the provision of suitable housing, proper nourishment and other amenities much more difficult than during normal times. Most of the poorer class homes are single room tenements and the inmates live under conditions of great overcrowding. Satisfactory isolation is therefore impossible unless more suitable accommodation can be found for the whole family. It seems essential that postwar plans for improved housing for the people should take into consideration the fact that, in a country like India with its high incidence of morbidity, domiciliary treatment of disease will have to play a large part in the provision of adequate curative and preventive health care to the community. Apart from tuberculosis, the common infectious diseases, and particularly those affecting children, will have to be treated in the homes of the people and the provision of a room where suitable isolation can be practised is therefore essential. This matter should receive consideration in formulating our proposals for the control of tuberculosis.

70. In spite of the handicaps to the working of the scheme under proper conditions, Dr. Sekand points out that organised home treatment has helped to render sputum-negative 15 per cent. of the cases and to bring to light the presence of active disease in about 12.2 per cent. of the contacts of patients. These are no doubt positive gains but the success achieved is hardly sufficient to make an impression on the tuberculosis situation in the area under the scheme. In order that the needs of patients and of families may be met Dr. Sekand estimates that, in each area, a sum of Rs. 300 per year for a population of 1,000 would be required for the satisfactory working of the scheme. On this basis each ward with an approximate population of 80,000 will require Rs. 9,000 per year while the money available at present is Rs. 1,500.

71. When the scheme was initiated, four doctors volunteered to visit patients in their homes on payment of a nominal fee of Rs. 2 per visit. But, owing to the calls on the doctors' time and the unremunerative nature of the payment given to them, they gradually ceased to function and the scheme had to fall back on whole-time doctors employed by the clinic. An extension of the scheme on effective lines can be carried out through the employment of whole-time doctors who are prohibited private practice, provided the remuneration offered is sufficient to secure proper men and to keep them to the job.

72. We have described this domiciliary antituberculosis service in Delhi at some length in the hope that the experience gained here will be of value to health administrations elsewhere, when the development of a similar organisation is attempted.

73. We have already referred to the fact that the total accommodation available in the country for tuberculosis patients is about 6,000 beds. There are 66 sanatoria and tuberculosis hospitals and antituberculosis clinics. Of the former special mention should be made of the institution under the Union Mission at Madanapalli and of a sanatorium at Badar in Hazara District in the North-West

Frontier Province. Both are doing excellent work. The latter is maintained by the Provincial Government. In relation to the vast problem that tuberculosis constitutes in this country the existing provision for the treatment of such patients is altogether inadequate. A wide expansion of institutional provision and of other antituberculosis activities will be necessary if the disease is to be brought under proper control

### SMALLPOX.

74. Smallpox is one of the three major epidemic diseases of India, the salient features of which are well known to the public. Therefore, although no completeness can be claimed for the recorded incidence of this disease, health authorities believe that the figures give, for individual areas and for the country as a whole, a fairly clear picture of the prevalence of smallpox and of its exacerbations from year to year. A striking feature of the disease is its variability in incidence. For instance, within the period of 60 years from 1880-1940, the average annual rate of smallpox mortality per thousand of the population has ranged from 0.1 to 0.8. Even after making allowance for such variability, there is reason to believe that the total incidence of the disease has decreased in the country as a whole. For instance, if the two ten-year periods, 1902-11 and 1932-41, are compared and due allowance is made for the increase in the population of the country, the rates of mortality from smallpox per 100,000 of the population are seen to be 40 and 25 respectively. Nevertheless, it is a matter for serious concern that the average number of deaths per year from smallpox for the period 1932-41 should have been as high as 69,474. The annual epidemiological reports which are published by the League of Nations show that the rate of incidence of smallpox in India is the highest among all the countries for which statistics are given. That the large amount of suffering and mortality for which smallpox is responsible should be permitted to continue is all the more regrettable because we have in vaccination a powerful weapon with which the disease can be kept under effective control.

75. Of the total number of smallpox deaths at all ages high proportions occur among infants under one year of age and among children between one and ten years. During the five-year period, 1937-41, deaths due to smallpox among infants under one year, when expressed as percentages of the total mortality from this cause at all ages, ranged from 12.1 to 19.7 and, during the same period, the corresponding percentages for children between one and ten years varied from 19.2 to 30.5. Such high rates of incidence of the disease among children at these two age periods have been a feature common to practically every province in India. If effective primary vaccination is being enforced in the country, it is children under ten who should have the highest measure of protection and it seems to us that the continued high rates of smallpox mortality at the two age periods is a clear indication of the inadequacy of existing administrative measures to enforce primary vaccination.



76. One of the serious consequences of smallpox is that, not infrequently, those who recover from it lose their sight partially or wholly. Blindness is a very serious handicap in life to all persons and is particularly so in the case of children with the prospect of a much longer period of disability than for those who lose their sight at a more advanced age.

#### **Vaccination against Smallpox**

77. Vaccination was the first preventive measure which was introduced in India and practised on a large scale. It was introduced first into Bombay in the year 1830 and a Vaccination Department was formed in 1858. Other Provincial Governments also developed Vaccination Departments in due course and the practice of this preventive measure has therefore been prevalent in the country for well over three quarters of a century. Nevertheless, primary vaccination is compulsory only in about 81 per cent. of the towns of India and 62 per cent. of the rural circles. Indeed, in Bombay Presidency, which first adopted vaccination, primary vaccination is enforced only in 4.9 per cent. of the rural circles, while in the North-West Frontier Province, the United Provinces, Sind, Coorg and Ajmer-Merwara it is not compulsory even in a single rural circle. The position as regards revaccination is even worse. It has been compulsory in the province of Madras for the past decade or a little more. In other parts of India, compulsory revaccination is enforced only as a temporary measure through special regulations issued under the Epidemic Diseases Act, when an outbreak of the disease on a large scale makes it necessary for the health authorities to adopt this measure.

#### **The Manufacture of Vaccine Lymph**

78. This is undertaken at seven provincial centres, *e.g.*, Ranchi (Bihar), Nagpur (Central Provinces), Guindy (Madras), Calcutta (Bengal), Patwa Dangar (United Provinces), Lahore (Punjab) and Belgaum (Bombay). In each of the above centres vaccine production follows generally accepted lines and there is therefore no need for departure from the existing practice. This view is based on the enquiries which we were able to make during our tours as well as on the report of a special officer deputed by the Public Health Commissioner with the Government of India, who visited each of the above centres in order to enquire into production methods.

#### **The Distribution of Lymph**

79. The methods of distribution of vaccine lymph, from the point of view of its keeping its potency during use in the field, has been, we understand, one of the subjects into which the officer on special duty, to whom we have referred above, investigated and an improvement of the existing practice seems desirable in order to prevent deterioration in the quality of the lymph. In these days of increased facilities for cold storage made possible by the use of thermos flasks and electric or non-electric refrigerators, advance in this direction should present little difficulty.

### The Vaccinator

80. The conditions of service of the vaccinator require considerable improvement in certain provinces before efficient work can be expected of him. This subject has been fully discussed in Chapter III of this volume.

81. Another matter for consideration in this connection is whether the continuance of this special class of worker is necessary. Smallpox vaccination is only one among the many forms of preventive vaccination which the health department should carry out for protecting the community and the process is relatively of a simple nature. However desirable the maintenance of a special class for smallpox vaccination might have been in the past, it is for consideration whether, in a modern health organisation such as the one which India will be expected to develop for herself in the postwar period, there is room for this type of health personnel. A man who knows that his days will be spent on work of an unpopular and routine nature and that his pay will be low can hardly be expected to play his part with energy and zeal in the new health order we envisage.

### The Vaccination Season

82. In all provinces there seems to have grown up the practice of carrying out routine vaccination mainly during the cooler months of the year. The reason for this is, we understand, the need for avoiding deterioration of the quality of the lymph during transit from the laboratory where it is produced and during its use for vaccinating the people. The period during which large scale vaccination operations are performed in the provinces thus becomes limited to six or seven months in the year. This is, in our view, unfortunate because what is required is an intensive effort to immunise the community as a whole and to keep up the high level of protection so attained by periodical revaccination. A lengthening of the vaccination season to cover all the twelve months is highly desirable. The development of the necessary facilities for cold storage and for the transport of vaccine lymph for use in the field should not prove difficult in the coming years.

## CHOLERA

83. Cholera is another preventable disease which takes a heavy toll of life in the country and shows a wide range of variation in its incidence from year to year. Below are given figures for cholera mortality in British India, excluding Burma, as averages for quinquennial periods from 1877 to 1941:—

Period	British India (Excluding Burma) Annual average	Period	British India (Excluding Burma) Annual average
1877-81 . . . . .	288,949	1912-16 . . . . .	328,593
1882-86 . . . . .	286,105	1917-21 . . . . .	392,070
1887-91 . . . . .	400,934	1922-26 . . . . .	143,890
1892-96 . . . . .	443,890	1927-31 . . . . .	297,756
1897-01 . . . . .	383,294	1932-36 . . . . .	140,440
1902-06 . . . . .	367,160	1937-41 . . . . .	147,423
1907-11 . . . . .	397,127		

84. In spite of the smoothing introduced by averaging in five-yearly periods the range of variation is extensive, from about 141,000 to 444,000. If the figures for individual years were examined, the variation in incidence would be found to be even higher. Some idea of the range of variation in the annual incidence of the disease may be obtained from the cholera mortality figures for the province of Madras in 1939 and 1943. In the former, total deaths from cholera was 2,115, the lowest incidence recorded for 60 years. In 1943 the disease spread to every district in the province and the registered mortality from this cause was 117,039. The incidence of cholera varies from province to province, those in which its prevalence is high being Madras, Bengal, Bihar and the Central Provinces and, to a smaller extent, Orissa and the United Provinces.

### The Epidemiology and Control of Cholera

85. The main facts regarding the epidemiology and control of cholera have been known for some time past. The disease is caused by an organism which is given out in very large numbers in the motion and the vomited material of cholera patients. The usual mode of spread of infection is through the transference of the organism either to drinking water or to food and its subsequent ingestion by healthy human beings. Contamination of food generally takes place through flies while water supplies, particularly in the rural areas, are infected by ignorant villagers carrying infective material from houses in which the disease occurs, into common sources of water such as tanks, wells or other forms of supply.

86. The measures which are required for the control of the disease fall broadly into two groups, (a) those which are permanent and (b) those which are of a temporary nature. The former include the following:—

- (1) the provision of protected water supplies;
- (2) the satisfactory disposal of nightsoil so as to prevent the possibility of contamination, by infective material, of food and water supplies and
- (3) sanitary control over the production, distribution and sale of food.

87. In regard to each of these the position in India to-day is far from satisfactory. Protected water supplies are available only in the larger towns and cities and they serve only small proportions of the population in individual provinces. Provision for the proper collection and disposal of nightsoil is quite inadequate in rural areas and in the majority of urban centres, including many towns and even certain cities. The sanitary control exercised over the production, distribution and sale of food leaves much to be desired in all parts of the country. We have discussed these matters in the relevant chapters of this volume of the report and need not therefore traverse the ground again here.

88. Anticholera measures of a temporary nature are of special value when an outbreak of the disease takes place. These include:—

- (1) isolation and treatment of patients;
- (2) disinfection of infective material and
- (3) immunisation of the people by anticholera inoculation.

89. As regards (1) and (2) above we have already shown earlier in this chapter that, under existing conditions, little or no effective action is being taken in large parts of the country, particularly in the rural areas. As regards anticholera inoculation, the popularity of this measure has been a process of steady growth. The people have come to recognise its value and are, broadly speaking, willing to accept inoculation when an outbreak of the disease takes place. They are, however, unwilling to submit themselves to it in anticipation of a possible spread of the disease to the area where they live. The fact that the protection conferred by an inoculation lasts only a few months might be a contributory factor to this attitude of indifference towards anticipatory vaccination against the disease. At the same time, the people have responded, in the recent past, to the appeal of the health authorities for mass inoculation during epidemics in a remarkable manner. During the past few years, when the abnormal conditions arising out of the war produced widespread outbreaks of the disease in many parts of the country, millions of inoculations were carried out. For instance, in Bengal alone, within the period from 1st November 1943 to the end of September 1944, about 18 million inoculations were performed.

#### **Part played by Festival Centres in the spread of Cholera**

90. Festivals, which attract large gatherings of people from different parts of the country, have played an important part in the incidence of the disease. In more recent years the sanitary control of these festivals on an extensive scale has been undertaken by provincial health authorities with a considerable measure of success. Even with such precautions the possibility of a large-scale outbreak of cholera resulting from such festivals was demonstrated in April 1938 when the disease, starting at the Hardwar festival, spread far and wide over the provinces of the Punjab, Delhi, the United Provinces, Bihar and the Central Provinces. In the circumstances the compulsory inoculation of persons, who are permitted to visit such festival centres, would constitute another important measure to strengthen the fight against the disease. The Central Advisory Board of Health advised, on the basis of a report by a special Committee which it appointed, that Provincial Governments should introduce an indirect form of compulsory inoculation through the prohibition of entry of uninoculated persons into festival centres. This suggestion has been tried in more than one province and has, on the whole, proved to be of value.

#### **Endemic Centres of Cholera**

91. Certain parts of India are considered to be endemic foci of cholera infection in that it tends to break out in such places every

year at the appropriate cholera season. Such centres are said to exist in Bengal and in the Cauveri Delta in the province of Madras. These endemic foci are held to be the places from which the disease spreads to other parts of the country, where cholera occurs often only at intervals of a few years. Therefore, from the point of view of the country as a whole, it would seem desirable that the permanent measures, to which we have referred in an earlier paragraph, should be applied to such endemic centres of the disease, in order that these sources of infection may be effectively controlled and cholera eliminated from them. This view has been upheld by the findings of an extended enquiry into the epidemiology of cholera, which was carried out in this country between 1934 and 1940 under the auspices of the Indian Research Fund Association. A review of these studies was published a few years ago and it states that "the problem of primary importance in the epidemiology of cholera is the existence of endemic areas in which cholera is permanently present . . . . Cholera is eminently a controllable disease . . . . It is obvious that the point at which preventive measures should be applied is the area from which the infection is primarily derived—this is in the endemic areas".

### PLAGUE

92. There is reason to believe that plague was prevalent in India many centuries ago and that the infection continued to exist among rats in the south-western Himalayan region. The history of plague in recent times dates from 1896 when it was introduced into the seaport of Bombay from China and spread rapidly over very large parts of the country. In 1904 deaths from this disease reached the very high figure of nearly 1,150,000. Since then there has been a gradual decline in the incidence of plague till, within the past ten years, its prevalence has become reduced to a considerable extent. The figures given below, which are quoted from the Preliminary Report of the Public Health Commissioner with the Government of India for 1939, indicate clearly this decrease in the incidence of plague.

#### *British India.*

Period	Total plague deaths.	Figures in column 2 expressed as percentage of total deaths during 1898-1938	Annual average
1898-1908 . . . . .	6,032,693	49	548,427
1909-1918 . . . . .	4,221,528	34	422,153
1919-1928 . . . . .	1,702,718	14	170,272
1929-1938 . . . . .	422,880	3	42,288
	12,379,819		

The average annual mortality from this cause during the three years 1939, 1940 and 1941 was only 19,347 or 45.7 per cent. of the corresponding average for the ten-year period, 1929-38.

### The Epidemiology of Plague

93. Plague is primarily a disease of certain rodents and human infection on an appreciable scale takes place only under conditions favouring close association between man and such rodents. In certain parts of the world, plague infection among such animals never dies out and these constitute endemic areas from which infection spreads to other regions from time to time. In India the animal is the rat while in South Africa it is the gerbille, in California the ground squirrel and in South-eastern Siberia and Manchuria it is the tarbagan. Periodically outbreaks of the disease take place on a large scale among such animals and destroy large numbers of them. For a time the infection lies dormant but, when the animals breed and a large susceptible group is produced, an epidemic wave starts again.

94. Man becomes infected from such animals through the bite of the fleas which live and feed on them. Without going into details regarding the mode of transmission of infection it will be clear that opportunities for close association between man and the special rodent responsible for keeping alive plague in the area concerned is a very important factor for the production of the disease in human communities. Widespread outbreaks among such animals may lead to territorial extensions of plague while the transportation of infected rats or infected fleas through grain traffic or in other ways may result in the starting of the infection in areas far removed from the endemic foci of the disease.

95. Plague appears in two main forms, bubonic and pneumonic. The former is characterised by the development of buboes or swellings in the groin, arm-pit or neck of the patient and, although it is the less severe form of the two, the rate of mortality may be as high as 60 to 70 per cent. among those who are attacked. It is in the transmission of bubonic plague that the rat and certain types of rat fleas play their part. Pneumonic plague is a form of severe pneumonia set up by the plague germ and its infection is conveyed from person to person through the air. The chance of any one in contact with a patient contracting pneumonic plague is very high and the rate of mortality is practically cent. per cent.

96. The epidemiology of plague in India, which is mainly of the bubonic form, was worked out by the Indian Plague Commission. The role of the rat and the rat flea in the transmission of the disease was demonstrated by this Commission. One of the workers on it, Haffkine, developed the anti-plague vaccine which has been in use in the country for conferring protection against the disease. The Provincial laboratory in Bombay, in which plague investigations were initiated, was named after him as the Haffkine Institute and it has continued to be the centre of plague research in the country since that time.

97. Although the incidence of plague has become very much reduced within recent years, the present Director of the Haffkine Institute, Lt.-Col. S. S. Sokhey, I.M.S., considers that certain endemic areas exist in different parts of the country and that they

constitute a constant threat in as much as, under favourable conditions, the disease may spread from these centres to other parts of the country. These centres are situated in cool and moderately damp areas in different parts of India, from the Himalayas in the north through Central and Eastern India to the Deccan and the province of Madras. They are therefore fairly widely distributed and, in view of the past history of plague not merely in India but in other countries, which shows that, during certain periods, the disease may spread widely and, at others, exhibit a contraction in the territory covered and a marked decrease in the number of cases occurring in the affected areas, these endemic centres may continue as potential sources of danger to the country as a whole, unless they are effectively brought under control.

### **Plague Preventive Measures**

98. The measures which are necessary against the disease are mainly those directed against the rat as the primary reservoir of infection from which the disease spreads to man. What is required is to prevent, as far as possible, the close association of man and rats. The keeping down of the rat population in inhabited areas, particularly in the endemic centres of plague, is therefore an important preventive measure. Rats grow in numbers in human dwellings only when they can secure food and adequate protection. The elimination of these conditions is therefore the purpose in view. The systematic destruction of rats by various methods so as to keep down their number is also another important measure which is adopted.

99. The steps to be taken for rendering the conditions in residential areas unfavourable to the growth of the rat population include (a) the construction of rat proof dwellings and rat proof grain stores and railway godowns, (b) control over the location of certain trades and industries which attract rats, and (c) an improvement of the general sanitary condition of the towns and villages, as the throwing of garbage in public places encourages the breeding of rats by providing them with food. As regards all these measures it may be stated that no effective action has been taken, in the past, by the authorities concerned in the endemic areas of plague so as to produce conditions unfavourable to the growth of the rat population. The destruction of the existing rats has also been carried out in far too perfunctory a manner to make any impression on their numbers.

### **Treatment of Plague Patients**

100. As in the case of cholera and smallpox the vast majority of plague patients, particularly in rural areas, receive no treatment for the disease. Fortunately, in the case of bubonic plague, the infection does not spread from patient to patient. Otherwise, the general absence of provision for the isolation and treatment of patients becomes another factor favouring the spread of the disease.

101. Till recently, there was no specific treatment for plague and the efforts of the physician were mainly directed towards giving relief to the patient and to the keeping up of his strength in the fight against the disease. The manufacture of a potent serum has been attempted by more than one investigator in different countries. A few years ago the Director, Haffkine Institute, prepared a serum which, on field trial, was established to be definitely more effective than the ordinary form of treatment. Sulphapyridin and sulphathiazole have also been found to be useful in the treatment of plague. Of the two, sulphathiazole is considered the better drug because its effectiveness is probably a little higher and its toxicity less.

### **Plague Research**

102. We have already pointed out that the Indian Plague Commission was responsible for discovering the more important facts regarding the mode of spread of plague and for showing the way for the organisation of preventive measures on sound lines. In more recent years extensive field research was carried out in the Cumbum Valley in Madura district of the province of Madras, which is one of the endemic centres of the disease. The length of life of the infected flea, methods of effective disinsectionisation of grain bags and other vehicles through which infected fleas and rats may transmit the disease, the effectiveness of cyanogas fumigation of rat-holes as an anti-plague measure and the evolution of a rat-proof hut suitable for rural conditions are among the various matters associated with the plague problem which the investigation unit in this area studied. As regards the use of cyanogas the conclusion reached was that, if systematically carried out in endemic areas, it helps to keep down the rat population and thus reduce the incidence of plague. At the Cumbum Valley a type of rat-proof hut was evolved costing less than Rs. 100 which was shown by close observation to have remained free from rats for two years. The popularisation of such a type of dwelling should prove useful in the campaign against plague.

### **Preventive Inoculation**

103. As in the case of cholera inoculation, the popularity of plague inoculation has steadily increased. The Director of the Haffkine Institute, Bombay, who is responsible for the manufacture and issue of plague vaccine for use throughout India, has pointed out that, in spite of a continued fall in the incidence of plague, the demand for plague vaccine has increased. When an outbreak of plague is imminent or when the disease is actually prevalent, preventive inoculation is the one measure which should be carried out with the greatest possible vigour.

## **LEPROSY.**

104. The number of persons suffering from leprosy in the world has been estimated as somewhere about five millions and, of these, leprosy patients in India are believed to be at least a million. The present distribution of leprosy in the world shows that its



incidence is high in certain parts of Africa, India, South China and South America. All the affected areas are in tropical or sub-tropical countries and only a few foci of infection persist in the colder countries. In India "there is a belt of high incidence including the whole of the east-coast and the south of the peninsula, including West Bengal, South Bihar, Orissa, Madras, Travancore and Cochin. In the central parts of India the incidence tends to be lower but there are some foci of higher incidence. There is a belt of moderate incidence in the Himalayan foot hills, running across the north of India, while in most of the north-west of India there is very little leprosy".\*

105. In the highly endemic areas its incidence may range from two to five per cent. of the population. In restricted areas in such endemic regions the proportion of cases may rise to 10 per cent. of the population while individual villages may show a rate as high as even 15 to 20 per cent. In the non-endemic regions of North-Western India, on the other hand, large areas may show no cases at all while the general level of incidence is stated to be as low as 0.01 per cent. or one per ten thousand of the population.

106. The public health aspect of the leprosy problem in an area is determined not merely by the rate of incidence of the disease in the population but also by the relative severity and infectiveness of individual cases. Cases of leprosy are broadly divided into two groups, the "neural" and "lepromatous" types. The former constitutes the "benign" form of leprosy and, as pointed out by the International Leprosy Congress, 1938, "these cases give evidence of relative resistance to the infection, or of relatively good prognosis as regards life although mutilation may take place . . . . . Bacteriologically the skin lesions are typically but not invariably found negative by standard methods of examination, though the nasal mycosa may be found positive". The lepromatous type consists, on the other hand, of the "malignant" form of leprosy, "in which the patient is relatively non-resistant, has a poor prognosis and exhibits lepromatous lesions of the skin and other organs, especially the nerve trunks. Bacteriological examination usually reveals abundant bacilli". It is therefore the lepromatous case that is usually much more infective than the neural case. While for the country as a whole the proportion of lepromatous cases is estimated at about 20 per cent. of the total number of leprosy patients, there are areas where the proportion of this severer type is as low as 4 per cent. and others in which it rises even to 50 per cent. The special Committee of the Central Advisory Board of Health, to which we have referred, has stated that "it is unusual in India to find an area where leprosy is both very common and severe. In Bengal, Bihar, Orissa and in the north-east part of the country in general, leprosy appears to be relatively common and relatively mild. In the foot hills of the Himalayas and in the areas to the north-west, leprosy is relatively

\* Report on Leprosy and its Control in India (1941) by the Special Committee appointed by the Central Advisory Board of Health.

rare and severe. In the south, *e.g.*, Madras, leprosy is very common but also more severe than in the north-east, though less severe than in the Himalayan foot hills". In estimating the importance of leprosy as a public health problem the rate of incidence and the relative proportion of the lepromatous type should both be taken into consideration.

### **Antileprosy work in India**

107. The first known leprosy asylum was established in Calcutta early in the 19th century. In the later years numerous other institutions were established by missionaries, local authorities and private benefactors.

### **Mission to Lepers**

108. But systematic attempts to bring medical relief to leprosy patients started with the foundation of the Mission to Lepers by Mr. Wellesley Bailey, who, coming to India in the Indian Police Service in 1869, was soon attracted to leprosy work and threw himself whole-heartedly into it. He established the Mission to Lepers and founded its first leper institution in Chamba in the Punjab in 1875. In the succeeding years the Mission extended its activities to such an extent that, in 1937, when Mr. Bailey died, there were 32 institutions in different parts of the country under its control providing accommodation for 8,000 patients. It is understood that the Mission also gives financial aid to 17 other institutions which admit 2,600 patients.

The total number of institutions for leprosy is about 95 with accommodation for about 14,000 patients.

### **The Indian Council of the British Empire Leprosy Relief Association**

109. Another institution which has taken an important part in the development of leprosy work in this country is the Indian Council of the British Empire Leprosy Relief Association. It was established in 1925 with funds raised by an appeal by Lord Reading, the Viceroy of India. A sum of Rs. 20 lakhs was collected and the interest from this amount constitutes the funds for the activities of the Association. It has its central office in New Delhi while branches exist in the different Provinces. Approximately one-half of the annual income of the Association is given to the provincial branches and the main activities of the latter have been the carrying out of leprosy surveys and the establishment and maintenance of treatment centres. The central organisation, on the other hand, has concerned itself mainly with the promotion of leprosy research, the provision of facilities for special training for doctors in the diagnosis and treatment of leprosy, propaganda work and co-ordination, through the provincial branches, of governmental and voluntary effort in the campaign against the disease.

### **Antileprosy work in the Provinces**

110. We may at this stage describe briefly the antileprosy work we saw in certain institutions during our tours in the provinces.

At Bombay the Ackworth Leper Home deals with pauper and non-pauper inmates and outpatients. There is usually considerable overcrowding, about 500 inmates being present while accommodation exists only for 400. Total figures for outpatients treated at the special clinic were 871 in 1941, 991 in 1942 and 1187 in 1943. The institution carries out a certain amount of field work in the way of follow-up of patients, examination of contacts and propaganda. For these two, specially trained health visitors are employed. The Executive Health Officer of Bombay Corporation is an active member of the managing board of control and is its secretary. Attempts have been made to introduce occupational therapy and a co-operative shop for the patients is managed by the inmates themselves. Facilities exist for private medical practitioners to obtain special instruction in leprosy, and lectures and demonstrations are arranged for students of the Grant Medical College.

111. In Orissa, a province in which leprosy is widely prevalent, we visited two colonies at Puri and at Cuttack respectively. To the Puri colony only infectious cases are admitted. The accommodation available at this colony is unfortunately limited. We understand that, if more accommodation were available, many more patients would willingly enter the institution and if separate provision could be made for better class persons, patients belonging to these classes would also probably be willing to accept segregation. The asylum at Cuttack is managed by the Mission to Lepers and provides for about 400 patients. Here there is provision for such activities as gardening, games, etc., and three schools are run separately for men, women and children. The Boy Scout and Girl Guide movements are actively supported by this colony. The institution provides special training in leprosy for medical licentiates and compounders. All the clothing required in the colony is made by the inmates themselves.

112. In Bihar the Mission for Lepers runs a large colony for about 860 patients in Purulia. Here much stress is laid on the systematic medical examination of patients and, for the last 20 years, a complete record has been kept of every patient in the home. The institution has a large and well attended outpatient department. Occupational therapy is practised and here also the clothes worn by the inmates are made by themselves. The Mission trains the more able-bodied patients to serve as nurses and attendants on other patients. The schools for boys and girls as well as the one for adults are, with one exception, entirely staffed by leprosy patients. Segregation of the healthy children of lepers in separate cottages has been provided for. There are several other large institutions in Bihar. We shall, however, refer only to the leprosy clinic in Patna, which is maintained from grants from the Provincial Government, the District Board and the Patna municipality and from certain charitable funds. No records of individual patients were maintained at the time of our visit and no attempt was made to organise follow-up work. We draw attention to these defects because we feel that an institution maintained at the headquar-

ters of a Province and which the Provincial Government supports should aim at a higher standard of performance.

113. The Central Provinces represent, as a whole, an area of low incidence, with, however, some areas of higher incidence. Eight leper asylums are maintained by the Mission to Lepers providing accommodation for some 2,100 inpatients. About 38 leprosy clinics are working in association with Government hospitals and dispensaries. In Wardha district some 500 lepers receive treatment at the outpatient clinic run by the Maharogya Seva Mandal, which also maintains hospital accommodation for 21 infectious lepers. Provision exists for follow-up, for the examination of contacts and for propaganda work. We were surprised that, at the clinic at Raipur, which is the headquarters of the Special Leprosy Officer for the province, no beds are provided and no follow-up work is attempted, the excuse being the absence of health visitors. We saw a very large settlement run by the Mission to Lepers at Chandkuri in Bilaspur district, which houses about 600 cases and is well maintained. There is also provision here for occupational therapy.

114. Active work on leprosy has been carried out in Madras in past years under the direction of Dr. Cochrane working with the Mission to Lepers. The two chief centres are Chingleput and Saidapet. Excellent institutional and outdoor work has been organised. In this connection we would refer to the reports by Dr. Cochrane and his colleagues on the work of the Saidapet health project and the Chingleput leprosy institution. Further, Dr. Cochrane has, through his advice to the Provincial health authorities, helped to promote a progressive policy in regard to antileprosy work in the province.

#### **Certain Special Aspects of the Leprosy Problem**

115. *The segregation of infectious lepers.*—Although the number of persons suffering from leprosy in India is estimated as approximately one million, in most parts of the country a high proportion of such patients, probably about 70 to 80 per cent., are in the non-infective stage. Even so, infective patients may number about 250,000 in the country. Although leprosy requires for its transmission close and prolonged contact and it does not therefore spread with the rapidity of diseases like cholera and smallpox, isolation of infective patients is the one measure which has been found to be effective in all parts of the world for the control of the disease. The need for such isolation becomes all the more emphasised when it is remembered that children are more susceptible to infection than adults and that the unsuspecting father and mother in an infective condition may continually be exposing their children to the risk of contracting the disease. While the estimated number of those requiring isolation is about 250,000 the total institutional provision for such isolation is in the neighbourhood of 14,000. No conceivable expansion of institutions in the immediate future can help to make up the large difference between existing provision and what is required to meet the needs of the country. The

need for developing group isolation under conditions suited to local requirements is therefore great. Schemes for this purpose must be sufficiently cheap if they are to be adopted on a wide scale, while they must also take into account the habits of life of the people and the special circumstances associated with the areas concerned. Attempts to develop group isolation have been made in different parts of the country in the recent past, but efforts in this direction must continue on the part of provincial health authorities before reasonably satisfactory schemes can be developed.

116. *The Problem of beggars with leprosy.*—Beggars with leprosy are found in varying numbers in a large number of towns and cities, in places of perennial pilgrimage and in all centres where pilgrims congregate periodically. The Special Committee has pointed out that, in Calcutta, there are about 1,000 beggars with leprosy, most of them having come from other provinces, and that the profession of begging has been organised by them to a high degree of perfection under a headman. Many of them are married to persons who are also suffering from leprosy and the quarters occupied by them are usually separated from those of the general population. In religious centres the common custom of giving alms to beggars and the frequent feeding by charitable persons constitute incentives which help to concentrate them in relatively large numbers. The large majority of these beggars are leprosy patients. While a certain proportion of them are burnt-out cases and are non-infective, the Committee points out that "the statement not infrequently made that almost all beggars with leprosy are not infective is not true".

117. *Leprosy in relation to industry.*—The Committee has thus briefly stated the problem:—

"During recent years some evidence has been accumulating to show that the development of industry is probably having an influence on the spread of leprosy and the possibility of this increase must be borne in mind. Leprosy surveys of industrial workers have been carried out in various parts of India and an incidence of between 1 and 2 per cent. has often been found, and a considerable number of cases have been infective cases. The presence of these infective cases in the crowded *busties* and living quarters of industrial workers is a definite menace to the other workers and their families. The fact that the industrial population of India is largely migratory increases the menace to public health. Not infrequently in village surveys one comes across patients with leprosy who attribute the disease to having been infected while working in industrial centres. Sometimes such a patient having contracted the disease in an industrial centre, will return to his village and introduce the disease there where it was not previously found."

#### **Leprosy Legislation**

118. Existing provisions for the control of leprosy are contained in (1) an all-India Act, the Lepers Act and (2) the provincial Local

Self-Government Acts. In the latter provision against leprosy is mostly confined to urban areas. The provincial Acts deal with leprosy in the same manner as the common infectious diseases such as cholera, smallpox and plague. In practice these powers have hardly been used by local bodies in respect of leprosy.

119. As regards the Lepers Act, its defects include that it makes no differentiation between infective and non-infective cases and that it deals with only certain classes of patients, namely, the beggar with leprosy, persons with the disease who prepare for sale or sell articles of food, drink, drugs and clothing, and with certain other matters such as the use of public wells and tanks by such patients for bathing and washing and the use of public conveyances by them. The Special Committee of the Central Advisory Board of Health considered that "this Act appears to be based mainly on considerations of public sentiment which cannot be ignored." Taking into consideration the deficiencies of this Central Act and of existing provincial legislation the Committee considered that comprehensive leprosy legislation should be undertaken and it has indicated certain principles which should guide such legislation. Reference may, in this connection, be made to appendix 19 in Volume III of this report.

## VENEREAL DISEASES

### Estimates of the Prevalence of Venereal Diseases

120. No reasonably accurate estimate of the incidence of venereal diseases in India (we include here only syphilis and gonorrhea as the two important diseases in this group) is available. As far as we are aware, the only attempt to estimate the prevalence of these diseases on a countrywide scale was made as part of an enquiry, the results of which were published in 1933, by Sir John Megaw, the then Director General, Indian Medical Service, into certain public health aspects of village life in India. This investigation based its findings on the replies to a questionnaire sent by him "to a large number of doctors whose dispensaries are situated in typical agricultural villages scattered throughout British India". Sir John estimated, on the basis of the figures he received, that there were probably about 5.5 million cases of syphilis and 7.6 million cases of gonorrhea. He pointed out that "syphilis and gonorrhea appear to be more common than has been usually believed; Bengal and Madras easily head the list. The data suggest that something like  $5\frac{1}{2}$  millions of people in India actually show signs of syphilis so that, if account be taken of those who have had the disease and have lost all obvious signs, it would probably be well within the mark to assume that 10 to 15 per cent. of the inhabitants suffer from syphilis at some time or other during their lifetime. The strikingly low rates of venereal disease in the Punjab are entirely in keeping with impressions based on other sources of information."

121. Existing statistics relating to these diseases are those of cases attending hospitals and outpatient clinics. Such figures are

not of much value in assessing the extent of their prevalence in the population as a whole. In reply to a questionnaire which we sent to provincial Administrative Medical Officers and Directors of Public Health, we received certain general remarks regarding the incidence of these diseases which, under the conditions existing in the country, can only be accepted as the impressions of the officers concerned. Even so, it may not be out of place to quote these remarks.

122. In Madras it has been stated that venereal diseases are prevalent "to an alarming extent in urban and industrial areas and pilgrim centres". It has also been pointed out that there has been an increase in these infections since the outbreak of the war. In Delhi, it is said that they are widely prevalent in the city, although no estimate of their incidence can be given. In the Central Provinces and Berar their incidence is said to be high in the districts inhabited by the aboriginals, while in the Punjab the Kulu Valley is the area which is most affected. A report issued by the Government of Bengal in March 1944, on its anti-venereal diseases campaign states that "the incidence of venereal diseases in Calcutta has of late been on the increase. Although correct statistics are not available, the figures obtained by the Director (of the venereal diseases organisation) from the leading medical practitioners of this city are alarmingly high. This increase is attributed to various changes in the social and economic conditions of life of late years".

123. It will be seen that, while no estimates of the probable incidence of these diseases are given, the opinion held by these different health authorities appears to be that their prevalence cannot be considered to be low, at least in certain parts of the provinces concerned, and that, during recent years, the tendency has been for their incidence to rise. Sir John Megaw's estimate gives a proportion of 37 per thousand of the population as showing signs of infection either by syphilis or gonorrhoea, a figure which is sufficiently high to justify a serious view of the situation and to demand that adequate measures should be taken to investigate their probable extent of prevalence in the country and that appropriate measures for their control should be taken in the light of such investigation.

### **The Treatment of Venereal Diseases**

124. The information given here is based on the replies to the questionnaire to which we have already referred. In all provinces these diseases are treated along with others in the larger hospitals. In certain provinces, however, special provision for the treatment of venereal diseases has also been made. The extent of such provision varies among the provinces. In Madras, for instance, it is stated that centres providing modern forms of treatment have been established by the Government in the city of Madras and in a number of places in the mofussil. In the city of Bombay there are four such centres maintained by the Government, two by the municipality and another two by the Port Trust.

It is also stated that venereal diseases clinics are working in association with civil hospitals in the mofussil with honorary veneriologists in charge. In the Punjab there are special clinics for these diseases in Lahore, Amritsar and in Ludhiana. On the whole it must be stated, however, that the existing facilities for the treatment of these diseases are insufficient to meet the requirements of the population.

125. Reference may also be made to a matter which is of great importance in the treatment of these diseases. The social stigma attached to them promotes concealment and the quack and his methods of treatment are likely to play an even more disastrous part in the treatment of these diseases than in the case of others. In certain countries the prohibition of treatment of venereal diseases by all except those who possess a registerable medical qualification and the restriction of advertisements regarding specific remedies and other forms of treatment to those approved by the health authority have been found useful in making the campaign against these diseases effective. In India no such restrictions exist at present.

#### **Training Facilities for Doctors**

126. The replies to our questionnaire show that, except in Madras and Bombay, no training facilities for doctors in the diagnosis and treatment of venereal diseases have been made available.

#### **Compulsory Notification**

127. Legal provision for the compulsory notification of these diseases does not exist anywhere in the country. Opinion as to the value of such a measure is divided even in those countries in which the venereal diseases campaign has been raised to a high level of efficiency. The opinion is held that, in view of the widely prevalent desire on the part of patients and their relatives to conceal the occurrence of these diseases, compulsory notification will lead more to concealment than to the active co-operation of the people with the authorities in securing early and adequate treatment for the infected persons. Indeed, the experience of England seems to point to the possibility of an effective control of these diseases being achieved, under normal conditions, through the provision of extensive facilities for free and confidential treatment, without having recourse to compulsory notification.

### **HOOKWORM DISEASE**

128. This is a disease which has received considerable attention from health authorities in many parts of the world. Probably the most notable enquiry into hookworm infestation was that conducted by the Rockefeller Foundation in the early part of this century in the Southern States of America. To that enquiry and subsequent ones carried out in other parts of the world by the same organisation we owe the fact that our knowledge concerning the cause, prevention and treatment of this disease may be held to be complete.



129. The male and female worms live in the human intestine. Large numbers of eggs of the worm are passed out in the stool and, in the absence of sanitary arrangements, are deposited on the ground. These eggs hatch and the larvae that come out continue to live in the soil, if favourable conditions of moisture and heat are present. When persons walk barefoot through such infected soil the larvae gain entrance through the pores of the skin and, after a complicated journey through the blood stream and the lungs, gain entrance into the intestines. Having completed growth by that time the worms become attached to the intestines. They produce their harmful effects partly by the loss of blood caused to the human host through their feeding on him, partly through causing a state of irritation in the bowels which interferes with the digestive function and partly through the secretion of a poisonous substance, which prevents the clotting of blood and thus promotes bleeding. The effects of infestation by hookworm have been well described in the report for 1917 of the International Health Board of the Rockefeller Foundation. Here is what the report says:—

“ Hookworm disease is never spectacular like yellow fever or pernicious malaria. And for this very reason it is the greater menace. Acute diseases sometimes tend to strengthen the race by killing off the weak; but hookworm disease, working so insidiously and frequently escaping the attention even of its victims, tends rather to debilitate the race by attacking the strong as well as the weak. The cumulative effects of the disease on the race—physical, economic, intellectual and moral—which are handed down from generation to generation through long periods of time, are even more important than its contribution to the death roll among individuals. This one disease, where the infection is practically universal, may go far towards explaining the retardation of backward peoples.”

130. Many investigations have been carried out into hookworm disease in India, among which special reference may be made to a systematic survey by Chandler in the years 1925-27. The distribution of the disease is as shown below:—

- (1) heavily infested areas are Assam, the Dooars and Darjeeling, Travancore, South Kanara and indeed all the tea gardens of South India and the tea and coffee plantations of Coorg;
- (2) moderately heavy infestation exists in Central Bihar, the eastern parts of the United Provinces and along the foot-hills of the Himalayas;
- (3) it is believed that about 60 to 80 per cent. of the population of Bengal, Bihar, Orissa, the Eastern parts of the Central Provinces, certain areas in the United Provinces and the Punjab, and east coast of Madras are infested with this condition, the average number of worms per individual, however, being not large;
- (4) the infestation elsewhere in India is low.

131. The fact that the disease is so prevalent in mines and on plantations is a grave reflection on the sanitary control exercised by the authorities responsible for labour in these areas. We have elsewhere recorded the unsatisfactory conditions of sanitation that exist in the coal mines and plantations of India and it remains to remark here that unless and until these are improved, many millions of people will continue to suffer unnecessarily from this disease.

### FILARIASIS

132. This disease is caused by the introduction of the embryo of a small worm known as filaria which is conveyed to human beings by mosquitoes. The prevalence of two types of this infestation has been noted in India, *Filaria bancrofti* and *Filaria malayi*. The former is more widely prevalent than the latter, which was first discovered in the Dutch East Indies some years ago and was shown, by Indian workers in this field, to be present in scattered areas in certain parts of India, namely, Travancore, Balasore, Patnagarh and East Bengal. The transmitting agents in the two cases are two different types of mosquitoes, whose methods of breeding are different. The disease is widely prevalent in certain parts of India. It leads to the permanent swelling of the legs and of certain parts of the body besides causing recurring attacks of fever and inflammation of the lymphatic system. Although the disease does not cause death it is responsible for a considerable amount of preventable suffering and disability.

133. Bengal is among the most heavily affected provinces in India. Both in Bihar and Orissa the disease is widely prevalent. Areas of moderate incidence exist in the districts of Tanjore, Kistna, Godavari and Vizagapatam in the province of Madras as well as in Saidapet, adjoining Madras City. The coastal tracts of Malabar and South Kanara districts and of the States of Travancore and Cochin are areas of high incidence. The control of this condition depends on the prevention of the breeding of the carrier species of mosquito and, in the areas indicated above, the necessary measures will have to be carried out effectively if the incidence of filariasis is to be definitely lowered.

### GUINEA-WORM DISEASE

134. Guinea-worm disease, another non-fatal infection, also causes much unnecessary suffering and disablement in many parts of the country. It occurs mainly in rural areas and agricultural labourers and other manual workers suffer largely in the affected areas. The worm is long and of a milky white colour and it lives beneath the skin commonly on the leg of the patient. A blister develops on the leg or foot and, when it bursts, a red ulcer is formed through which the worm can be seen. When the affected part comes in contact with water, the worm which is packed with embryos passes them into water. The embryos live in clean water for about a week and in muddy water for a longer period. They are swallowed by cyclops, which are small whitish transparent creatures of the size of a pin's head and are generally present in

most collections of fresh water. When a person drinks infected water, the cyclops are killed in the stomach by the gastric juice and the young worms are set free. They then pierce the tissues and enter the human body. It takes about 348 days for the embryo to grow into an adult worm inside the human body. The worm travels into such parts of the body as are likely to come in contact with water. In India it is stated that the worm appears in about 90 per cent. of patients in the legs. They also appear occasionally in other parts such as the arms, chest, back and abdomen. A patient shows generally only one worm at a time but multiple infections do sometimes occur. It is stated that twenty-two worms were removed from one individual from Rajputana at the Calcutta School of Tropical Medicine.

135. From what has been stated above it will be seen that the prevalence of the disease is dependent on opportunities for the infection of water supplies by persons harbouring the worm. In the affected areas step-wells, tanks and other sources of water liable to contamination are responsible for the keeping up of the infection. The destruction of cyclops by the application of adequate quantities of lime to such water supplies has been shown to be effective in controlling the spread of the disease. By boiling the water the cyclops and the embryos in them are both killed. Even straining the water through fine muslin will suffice to remove the cyclops and render the water innocuous. But, from the point of view of permanent relief, it is essential to protect step-wells, tanks and other open sources of water supply from contamination by persons harbouring the worm.

136. Guinea-worm disease is widely prevalent in certain districts of the North-West Frontier Province while its incidence is relatively low in the Punjab. The Rajputana desert is free but many of the States in Rajputana and Central India contain heavily infected areas. In the Central Provinces, Bombay Presidency, Nizam's Dominions and Madras Presidency the disease is prevalent over wide areas. Well watered tracts, with a fairly heavy rainfall such as Bengal, are generally free.

## CANCER

137. This is a group of diseases which have had a great deal of attention paid to them in Europe and America. On the other hand, there exists very little reliable information regarding the incidence of cancer in India. The most authoritative pronouncement on the subject has been provided by an investigation carried out by Drs. Vishwanath and Khem Singh Greval working with a grant from the Indian Research Fund Association. They published a series of papers in the Indian Journal of Medical Research. We cannot do better than quote the authors:

“ The age of maximum incidence of cancer in this country is at least ten years earlier than in Western countries and Japan and in the case of cancer of the female generative organs earlier by 15-20 years. In every province, including Burma, the incidence of cancer of cervix falls heaviest on

Hindu women. The incidence of buccal cancer falls heavier on the male than on the female and on Muslims more than the Hindus. This form of cancer has its lowest incidence in the Punjab, where *pan* chewing is not indulged in to the same extent as in other parts of India. Unhappily this habit is growing rapidly in that province as well. Penile cancer is peculiarly a disease of the uncircumcised communities and out of a total of 611 cases noted in biopsy records and 1,080 cases in clinical records, only 17 cases were recorded among Muhammedans in the former series and 29 in the latter.

"In the whole of this enquiry the aetiological roll of irritation in the incidence of cancer has stood out prominently. Whether it was the cervix, the oral cavity, the penis, the skin or the gastro-intestinal tract, the factor of irritation seems to excel all other possible causes and brings the problem of this fell disease within the scope of preventive medicine.

"Although this survey cannot fix decisively the relative position of cancer amongst the causes of mortality in India, it affords sufficient evidence as to its position being not insignificant. It should at least persuade foreign writers on the subject to be less dogmatic about the rarity of this disease in India. The writer of this note believes that if vital statistics were as carefully collected in India as they are in the West and proper allowance made for the number of individuals living per thousand at a given age, the incidence of cancer will be found to be independent of geographical and racial variations."

138. Other competent observers who have stressed the importance of this disease include Sir Leonard Rogers and Major General Sir Earnest Bradfield. The opinion has, however, been widely held, with insufficient justification, that cancer, in most of its manifestations, is comparatively rare in India. Gradually light is being thrown on the incidence of this condition, the setting up of the Tata Cancer Research Hospital in Bombay having given an impetus to investigation into this important field of study. This research and treatment institution has been in existence only for a few years but has already succeeded in gaining for itself a considerable reputation. We had the advantage of hearing the views of the Director of its laboratories, Dr. V. R. Khanolkar, and his assistants when we visited this hospital. He and others competent to express an opinion hold the view that the incidence of the diseases represented by this group in India is not likely to show any considerable variation from the extent of their prevalence in Western countries.

139. The Tata Memorial Hospital is the only institution in the country which is devoted entirely to the study of the diagnosis and treatment of malignant disease. Radium and deep X-ray therapy are available for therapeutic treatment in a very limited number of places in the country. A list of such places will be found in Appendix 20 of Volume III of this report.

## MENTAL DISORDERS AND MENTAL DEFICIENCY

### **Estimate of Persons suffering from Mental Ill-health**

140. Conditions of mental ill-health may be divided into two broad groups, (1) mental disorder and (2) mental deficiency. No estimate of the number of persons suffering from either of these two groups of mental conditions is available for India. It may therefore be of advantage to examine such evidence as is available regarding the incidence of these conditions elsewhere and attempt to draw from it inferences applicable to this country. In England and Wales there were, at the beginning of 1937, about 129,750 patients under treatment in the mental hospitals maintained by the various local authorities, who are responsible under the law, for making such provision. This figure gives a proportion of 3.2 mental patients per 1,000 of the population. In America the rate of admission to mental hospitals has varied from 5 to 8 per 1,000 in different years and in different States. In India there is no reason to believe that the rate of incidence of mental disorders is likely to be much less than those for England and the United States. While purely sociological causes may not be operative in India to the same extent as in the other two countries, chronic starvation or under-nutrition, tropical fevers, anaemia and frequent child-birth in women, who are unfit for motherhood, are responsible for large numbers of cases of mental breakdown in this country. Even if the proportion of mental patients requiring hospitalisation in India be taken as 2 per 1,000 of the population, their number will be at least 800,000 in the country as a whole. It does not, therefore, seem unreasonable to suggest that the number of persons suffering from various forms of mental disorder must be at least a million in this country.

141. As regards mental deficiency, an estimate of 8 per 1,000 of the population was made for England and Wales in a report issued in 1929 by the Joint Committee of the Board of Education and the Board of Control on mental deficiency. Even if the rate applicable to this country were half this figure, the total number of mental deficients in India as a whole becomes 1.6 millions, on the assumption that the total population is 400 millions.

These estimates are only conjectural; nevertheless, they help to indicate the magnitude of the problem that mental ill-health constitutes in the country and the extent to which remedial and preventive health measures will have to be developed, if adequate provision for this section of the community is to be made.

### **Provision for the Treatment of Persons suffering from Mental Disorders and Mental Deficiency**

142. In chapter III of this volume we have shown how the existing provision for medical relief and preventive health work in connection with the common forms of sickness is quite inadequate to meet the needs of the people. For mental patients the available facilities are of a still lower order. In this connection it may be mentioned that, at our request, Colonel M. Taylor, Medical Superintendent, Ranchi European Mental Hospital, undertook a tour of

the more important mental institutions in the country and prepared a report for us. It has been published as Appendix 21 in Volume III of this report. He has shown that the functioning of existing mental institutions is, in most cases, far from satisfactory. A list of these for British India, with the accommodation available in each, and the places where they are located is given in Appendix 22. The total accommodation available is about 9,889 beds and, if the States are also included, 10,189. When it is remembered that the probable number requiring institutional care may, on a conservative estimate, be at least 800,000 to 1,000,000 for the country as a whole, the inadequacy of the existing number of beds becomes unmistakably clear.

143. Apart from this, however, an even more important fact is the existing institutions are working at an extremely low level of efficiency. Colonel Taylor says, "the majority of the mental hospitals in India are quite out of date, and are designed for detention and safe custody without regard to curvative treatment. The worst of them—the Punjab Mental Hospital, the Thana Mental Hospital and the Nagpur Mental Hospital—savour of the workhouse and the prison and should be rebuilt."

144. As regards the medical staff employed in them he states that "seven of the largest mental hospitals in India have men appointed as Superintendents at salaries that a first class mechanic in Tatas Works would scorn, six of them have little or no post-graduate experience or training in psychological medicine". The subordinate medical staff are also untrained in psychiatry. The number of medical men employed is quite inadequate. He rightly points out that, with one medical officer for 200 patients, only cursory attention can be given to the patients, while the additional duties of teaching medical students, which some of these institutions are required to perform, are also carried out in a perfunctory fashion.

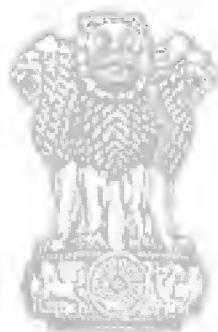
145. The position as regards nursing staff and ward attendants is equally unsatisfactory in most of these mental institutions. Inadequacy of numbers and insufficiency of training both contribute to make the standard of service of an extremely low order.

We do not propose to describe in detail individual institutions. For such details reference may be made to Colonel Taylor's report.

#### **Facilities for Mental Training for Medical and Other Personnel**

146. From what has been said above it will be clear that the need is urgent for providing training facilities for medical and non-medical personnel on as extensive a scale as possible. The staffing of existing institutions with qualified workers and an expansion of mental health activity in institutional and other fields will become possible only with a large output of trained personnel. At the same time it will be recognised, from the brief description given above of the working of existing mental institutions, that the large majority of them are ill-equipped to discharge teaching functions properly. One of the purposes of the tour which Colonel Taylor undertook at our request was to make an estimate of existing

training facilities in the mental institutions in the country. In his view such facilities exist on a reasonable scale at Bangalore and in Ranchi. At other places, *e.g.*, Calcutta and Bombay, a considerable improvement of certain existing institutions and the establishment of well staffed and satisfactorily equipped mental hospitals will be necessary to provide the conditions essential for developing them as proper training centres. These and other matters relating to the creation of training facilities in different parts of the country will be considered when we put forward our proposals for mental health services in the second volume of this report.



## CHAPTER X

### ENVIRONMENTAL HYGIENE

1. In this chapter we shall deal with environmental hygiene under four heads, (1) town and village planning, (2) housing, (3) water supply and (4) general sanitation.

#### TOWN AND VILLAGE PLANNING

##### **Introduction**

2. The purpose of town and village planning is to utilise the available land to the best advantage of the community, taking into consideration its various needs such as the provision of land for residential purposes, the development of agriculture and industries and the creation of recreational facilities. As has been pointed out by Mr. U. Aylmer Coates, Provincial Town Planner to the Government of the Punjab, town planning is "not merely a matter of planning streets or placing restriction on the size of sites attached to various types of buildings but is, broadly speaking, the allocation of land to its best economic use, the proper relation between buildings of different use and design, the improvement of existing conditions of habitation and securing that development functions both from the utilitarian and sanitary points of view and is also artistically satisfying".

##### **History of Town Planning in India**

3. A short history of town planning in the country will be found in the "Report on Town and Village Planning in India" by Mr. B. R. Kagal in Appendix 24 of Volume III of this report. The report of Mr. Kagal was based on his studies of town and village planning activities in the provinces and in the Indian States of Hyderabad, Mysore and Baroda as the result of a rapid tour undertaken at our request. Mr. Kagal points out that the Government of India began to take an interest in the subject in 1912 when the question of the selection of a site for the new capital in Delhi was under consideration. At the same time, it impressed on Provincial Governments "the great and growing importance" of town planning and suggested the enactment of legislation similar to the English Housing and Town Planning Act of 1909. In the years that followed active interest in town planning developed in the provinces also. Professor Sir Patrick Geddes and Mr. H. V. Lanchester, two leading town planners in England, visited India and advised the provinces of Madras and the Central Provinces and Berar and the States of Baroda, Gwalior and Indore on their respective planning problems. The United Provinces employed a full-time architect who prepared a master plan for Cawnpore. Another English town planner, Mr. E. P. Richards, prepared a report on the town planning of Calcutta and its surroundings. In 1921 the University of Bombay established a School of Sociology and offered its first professorship to Sir Patrick Geddes. In the mean time provincial town planning legislation had also begun to develop, an Act having been passed in 1915 in Bombay, in 1919 in the United Provinces, in 1920 in Madras and in 1922 in the Punjab.



4. After 1921 interest in town planning steadily declined in India, except in the Punjab and in the States of Hyderabad, Mysore and Baroda. As has been pointed out by Mr. Kagal "the interest taken by the Government of India from time to time was an 'occasional burst of insight' and was not sustained, and so was the response. The initiative for the town planning movement was taken by the Government 'from the top' instead of its coming 'from below', as in the case of England where the lead for reform in town and country planning was given by the public, the P.E.P. (Political and Economic Planning), the Town Planning Institute and the Royal Institute of British Architects. The Government accepted the lead and followed it up with necessary enquiries and legislation. In contrast, the Central and Provincial Governments in India have not taken adequate steps even to implement the recommendations made by the Holland Commission in 1918 on the scientific and technical aspects of town planning and by the Whitley Commission in 1930 on town planning legislation. As a rule, the Provincial Governments have not shown any active interest in the subject until recently when post-war problems came to the fore".

5. In the States of Hyderabad and Baroda selected persons were sent abroad to study the theory and practice of town planning for a period of years and, on return, they were given full opportunities for developing town planning in these States with the co-operation of the public health and other departments of Government. In Mysore, on the other hand, foreign experts were brought in and the main town planning activities have been confined to the two cities of Mysore and Bangalore. No attempts have been made to train local people either by sending them overseas for the requisite specialisation or by instituting appropriate courses in the Mysore University. Thus when the present experts leave the State the likelihood of planning activities continuing to develop are definitely less in Mysore than in the other two States.

### **Village Planning**

6. Even less attention has been paid to village planning in this country than to town planning. Most villages have grown in a haphazard manner and, in far too many cases, it would be beyond the capacity of a planner to improve existing conditions to any reasonable extent. To indicate how difficult such planning would be we may describe the layout of existing villages in certain provinces. In the United Provinces the villages are usually fairly compact, but no regular streets have been laid out and the houses are built with little relation to one another and facing in any direction. In Delhi province village streets are not well laid out and they scarcely justify the term "street". In Orissa villagers construct their houses without any consideration to the requirements of sanitation and without paying attention to the relationship of one house to another. In the Punjab no provisions exist in the District Boards Act to regulate the construction of houses in rural areas. Detailed instructions have, however, been given in the Punjab Colony Manual with regard to the selection of

village sites and the way in which villages in colony areas are to be laid out. Type plans have been prepared for houses of different kinds suitable for village construction.

### Planning in Urban Areas

7. As regards towns, progress in town planning has been extremely slow. During the last 20 or 25 years although, as has already been pointed out, certain eminent town planners visited India and offered advice to Provincial Governments and, in certain cases, even prepared definite schemes for individual cities, very little action has been taken. In some of the larger cities in the country Improvement Trusts have been working for some time and, although their specific purpose is to assist in the planning of these cities, the results achieved have been very limited. We shall now refer briefly to what has been done in individual provinces and cities.

8. *Calcutta*.—The activities of the Calcutta Improvement Trust are confined mainly to the acquisition of land, the laying out of roads and the development of areas in order to sell them outright to purchasers. During the existence of this Trust it has not, as far as we are aware, undertaken any housing schemes at all, although provision for the re-housing of those who will be deprived of their houses by slum clearance operations should be an essential function of a trust. It is understood that the regulation of building construction on the cleared areas has, throughout, been the responsibility of the Calcutta Corporation and laxity in the enforcement of building byelaws has led, in some cases, to the creation of congested conditions in areas which had previously been subject to slum clearance at the hands of the Improvement Trust. So far as the interest evinced in the orderly development of the city is concerned, we may refer to the fact that Mr. Kagal reported that no copy of the comprehensive report on the planning of the city which was prepared by Mr. Richards in 1915, to which we have already referred, could be obtained in the office of the Calcutta Improvement Trust.

9. *The United Provinces*.—It is understood that the Allahabad Improvement Trust has provided new roads in certain congested areas. The Lucknow Improvement Trust has developed some sites. The Improvement Trust in Cawnpore city has started large scale housing projects for labourers which we saw during our tour and we consider the scale of accommodation insufficient and ventilation defective. Sanitary amenities are inadequate. The Superintending Engineer of the Public Health Department in that province has pointed out that the projects undertaken by these Trusts do not obtain the technical approval of any responsible engineer or officer of the Government, particularly in so far as drainage and sewage proposals are concerned.

10. *The Punjab*.—In this province there is a provincial town planning officer who acts as adviser to the Lahore Improvement Trust. Planning schemes for unbuilt areas have recently been prepared for this city, but they have not so far been put into operation. It is understood that both Amritsar and Lyallpur have

submitted town planning schemes to the Provincial Town Planner for approval. The latter has since his appointment prepared, it is understood, schemes for 22 areas and has also considered 132 schemes relating to 25 towns in the province. Reference has already been made to the Punjab Colony Manual which deals chiefly with the layout of village sites in areas under the control of the Irrigation Department. The rules which have been framed are satisfactory, but as far as we are aware, no attempts have been made to prescribe a standard type of building for these areas. As long as the grantee fences his compound with a wall and constructs something which may be called a house, the details of architectural design are left for individual taste to decide.

11. *Biḥar*.—In Bihar an Improvement Trust was set up by the Provincial Government in 1915, but the success achieved has been meagre. It is, however, gratifying to note that the Provincial Government is now taking up energetically a suggestion made to it by a Commissioner of one of the Divisions in the province. The proposals now under consideration contain certain features which can, with advantage, be copied by other provincial authorities. These are (1) insistence on a twelve month programme in the case of superseded municipalities; (2) legislation for the provision of executive officers with statutory powers in specified municipalities; (3) a joint provincialized service of executive officers for municipalities; (4) stricter supervision by Government in regard to the enforcement of building byelaws and (5) the provision for the constitution of water works committees in all municipalities which have a piped water supply.

12. *The Central Provinces*.—The Government is, it is understood, considering a town Planning Act after an investigation of existing unsatisfactory conditions in the capital city of Nagpur and in other places. The idea is that a provincial body deriving its authority from a special Act should proceed to plan and direct, in a unified and co-ordinated manner, the development of town planning activities in the province as a whole. While this is certainly commendable, it is understood that a draft Town Planning Act, which has been prepared, has taken the Bombay Town Planning Act of 1915 as its model. The latter is out of date and does not contain even certain important provisions in the Madras Town Planning Act of 1920. Indeed, the Whitley Commission in 1930 suggested that Bengal and Bombay should have Town Planning Acts on the model of Madras. In the circumstances it is difficult to understand why the Bombay Act should have been taken as the model.

13. *Madras*.—Although the province of Madras is unique in having an elaborate Town Planning Act and a Public Health Act, which also contains provisions relating to town planning, the actual standard of performance has been disappointing. Mr. Kagal has pointed out, in appendix XIV of his report, that "the important section in the Madras Town Planning Act is Section 8 which makes it obligatory on certain Councils to make general town planning schemes not later than 31st March 1934.....By November 1944, not a single Municipal Council in the Province, out of 89

including the City of Madras, has submitted the general town planning scheme contemplated by section 8".

14. The province originally had a Director of Town Planning. This fact was commented upon favourably by the Royal Commission on Labour in India and was held forth as an example that "other provinces might well follow". In 1934 the post was reduced to that of a second class officer and a candidate possessing the minimum qualification was appointed in 1935. In 1938 it was abolished on the somewhat extraordinary ground that "the general principles of town planning are now fairly well understood and it should be possible for the town planning committees (Municipal Councils and Local Boards) to apply them in individual cases of planning and development with the advice of the Inspector of Municipal Councils and Local Boards and *ex-officio* Director of Town Planning". This combined office is held by an officer belonging to the Indian Civil Service with no technical competence to advise on town and village planning. It is clear that the provincial authorities have failed to recognise the importance and technical nature of the duties that the Town Planning Director should perform. The comments of Mr. Kagal on town planning activities in Madras are worth quoting: "Madras has a lesson to teach. Unless Government attitude is more positively sympathetic and helpful, unless municipal administrations are more efficient and show better civic responsibility, the best town planning legislation will be unable to produce the desired results".

15. From what has been said in the preceding paragraphs it will be seen that, in the country as a whole, the question of town and village planning has so far failed to receive the attention it deserves. In the case of Madras, failure to put into operation the existing legislation has been largely responsible for the present state of undeveloped activity in this field. We also consider that, unless Provincial Governments are prepared to employ competent technical advisers little advance will be made. Provision for such technical guidance will be required not only at the headquarters of the province but also in the larger urban centres in which Improvement Trusts or other organisations are carrying out planning operations. In the past the civil engineer in the Public Works Department has been considered competent to deal with town planning. Town and village planning constitute activities for which special training is essential and until competent technical guidance is made available, progress in this field will continue to be unsatisfactory. The Central Provinces Government has put forward a valuable suggestion that a provincial body should be established which, deriving its powers from a special Act, should guide and co-ordinate town and rural planning activities in the province as a whole. This idea may, with advantage, be adopted in other provinces also. Lastly, planning involves expenditure, often on a large scale, and Provincial Governments will have to shoulder the responsibility of promoting developments in this field by suitable grants-in-aid to the local bodies or other authorities which are entrusted with the task.

## HOUSING.

16. Existing housing conditions are, generally speaking, extremely unsatisfactory in rural and urban areas. The growth of housing accommodation in the country has not kept pace with the increase in population and over-crowding is therefore a common feature, particularly in the towns and cities. In addition, the requirements of sound hygienic construction have largely been neglected, while the state of insanitation that exists in towns and in the countryside helps to reduce still further the value of the home as the place which should provide reasonably satisfactory living conditions for the maintenance of the health of its inmates. Proper housing has a profound influence on the health of the people. We may, in this connection, make specific reference to three groups of diseases, namely, tuberculosis, venereal diseases and bowel complaints such as dysentery, worms and typhoid, the incidence and spread of which are profoundly affected by the housing conditions of a community.

17. Before describing briefly housing conditions in the rural areas, we shall make certain general remarks. The materials for house building, which are commonly used by the poorer classes throughout India, namely, mud and bamboo matting, are not in themselves undesirable. They have the great advantage of being cheap and they can, with a little care, be so used as to produce a respectable house. The common thatched roof brings with it the danger of vermin and of insects as well as a continual threat of fire. When sensibly utilised and properly supervised, however, a thatched roof can be made reasonably serviceable. In many parts of India tiles are not easily procurable. While therefore the poor man's dwelling, although it be a structure of mud walls and thatched roof, need not necessarily be unsatisfactory from the point of view of comfort and of hygienic construction, there are certain other essential requirements which must be met. These include the provision of more than one room to each house, the exact number depending on the size of the family, separate cooking accommodation with provision for leading away smoke and washing facilities. Adequate light and ventilation should also be provided. Further, the demands of sanitation require that there should be a latrine for each house. We have indicated elsewhere that, in many parts of the country, a cheap solution to this has been found in the provision of bore-hole latrines. We consider these as the minimum requirements of a habitable house. Further improvements, if possible, may include a small garden properly fenced in for privacy and opening on to a decently metalled village road. There should be provision for the disposal of manure and garbage as well as for the maintenance of the village cattle, goats and poultry, these being arranged, as far as possible, on a common basis for the community as a whole.

18. The requirements we have suggested above for developing rural housing conditions on a reasonable basis can hardly be considered extravagant. As against this standard we may now describe existing conditions in the rural areas in certain provinces. In the United Provinces no attempt has so far been made to control rural

housing. The usual type of house consists of a court-yard with rooms which may be entered from it. There are generally no windows. The material used for construction is mud with a thatched or occasionally tiled roof. A separate latrine for a house is rare. Food is usually prepared and eaten in the court-yard, though occasionally a room may be set aside as the kitchen. In this and in other provinces it is a common practice for the villagers to permit cattle, goats and other domestic animals to share the available living space in the house with human beings. In the Punjab no provisions exist in the District Boards Act to regulate the construction of buildings in rural areas. It is understood, however, that steps are being taken to rectify this defect. In the rural areas of Bengal houses are generally built with mud walls or occasionally with bamboo matting. Windows are provided but they are insufficient in size. Latrines are rarely found. A common feature in this province is the *doba* or tank attached to each house or a group of two or three houses. The villages are scattered over a wide area and communication between houses is often very difficult. Indeed many villages, particularly in eastern Bengal, are completely isolated for prolonged periods during the monsoon. Rural housing conditions in Bombay are also very primitive and the conditions of insanitation that prevail are quite unsatisfactory.

#### Urban housing

19. Housing in urban areas in India is also very unsatisfactory. The enforcement of building byelaws in municipalities hardly exists. A typical reply to our enquiry about the enforcement of these byelaws was that received from the Director of Public Health of the Central Provinces. He said that "municipal committee members will not incur the risk of being unpopular through the enforcement of these byelaws". So long as local health authorities continue to maintain this attitude the enforcement of the law for improving existing housing conditions will be impossible.

20. We would also draw attention to certain other matters in this connection. We have been informed that, in the United Provinces, plans for the construction of houses in urban areas need not be approved by the Health Department of the municipality concerned. That department is responsible only for the location and specification of wells and sanitary conveniences. The Provincial Government has issued model byelaws laying down standards regarding open spaces, light, ventilation and sanitary equipment. But these are, as a rule, not enforced by the municipal boards. Health departments have no legal powers to prevent the use of houses unfit for human habitation, nor are they empowered to inspect the existing dwellings with regard to space, lighting, ventilation and sanitary arrangements. It would therefore seem that the authority primarily concerned with promotion of the public health has been excluded from exercising that supervision which is essential to ensure the maintenance of satisfactory standards. We understand that, in the large city of Agra, there were no building byelaws till July 1944 and that, since then, they have been applied ineffectively. In Orissa the Municipal Acts do not provide for the framing of

building byelaws. Building plans are examined by the public health and engineering departments of municipalities, where these exist. But the recommendations of these officers are, it is understood, generally ignored. In Bihar, of a total of 57 municipalities, 33 have adopted the model building byelaws which have been framed by the Provincial Government, but 24 have so far taken no steps to enforce them and, as far as we are aware, nothing has been done to rectify this negligence of a public duty. Here also, we understand that health officers have no powers for controlling the use of houses unfit for human habitation and for inspecting existing buildings as regards their sanitary condition. In the Punjab nearly all local bodies have adopted approved building byelaws but their observance is far from satisfactory owing to the lack of suitable supervisory staff. In Madras a housing survey recently carried out in Madura city revealed that 1,900 houses were overcrowded and that 2,500 were one-room tenements harbouring ten to fifteen families in each. In Coimbatore, a town in which it has been estimated that the population has increased by 170 per cent. during the past half a century, housing accommodation has grown during the same period to the extent of 20 per cent. The consequent overcrowding on the available housing accommodation can well be imagined. In Bengal we understand that building byelaws are applicable only in 44 municipalities and that, even in these, their enforcement leaves much to be desired.

21. In this gloomy picture there are a few bright spots. In Delhi Province a housing scheme was started some years ago, which we consider satisfactory in design, although we cannot but state that it should have been more energetically developed and that the houses under the scheme should have received more care and attention from the authorities concerned as regards the quality of their construction. The scheme is intended to re-house persons dispossessed of their homes as the result of slum clearance operations and, in order to make it financially sound, a subsidy has been made available by the Delhi provincial authority. Three types of dwellings are provided in the scheme, a one-roomed house for a family of not more than 3 adults, a two-roomed house for families of 3—5 adults and a three-roomed house for those having more than 5 adults. The first and second types are capable of expansion into the three-roomed class. The single-room house covers 102 sq. ft., the two-room type 204 sq. ft., and the three-room one 300 sq. ft. For each type of dwelling there is a cooking verandah and a bathing platform, the latter being connected with an outside surface drain. A fire place and flue are provided in the cooking verandah. We do not approve of the one-roomed house. We noticed that there was overcrowding, an insufficient water supply and an insufficient number of public latrines for this class of houses. While commending the idea underlying the scheme our criticism is that the Delhi Improvement Trust should have devoted more money and care to its details. We have already referred, in the chapter relating to industrial health, to a housing scheme promoted by the Madura Mills at

Harveypet, in which houses are built semi-detached, each consisting of two rooms with a verandah, a kitchen, a small store room and separate latrine. We are specially referring to these two schemes as attempts to deal with urban housing problems, because we desire to see that all provincial authorities become interested and devote adequate attention to a subject, which, from the point of view of the health and general well-being of the community, is second to none among the problems awaiting solution in the post-war period.

22. To sum up, in rural areas there has been, up-to-date, no planning and no control of housing. In municipal areas legal supervision exists for enforcing desirable standards of housing but these powers are not being used satisfactorily by the municipal commissioners concerned. The health department, which is intimately concerned with the maintenance of certain minimum hygienic standards, has not, generally speaking, been permitted in the past to exercise adequate control over either existing housing or new construction. In addition to these grave defects in the enforcement of the law relating to housing, all available evidence seems to point to the growth of population having far outstripped the development of new housing accommodation, the consequent deficiency having produced acute conditions in some of the larger urban centres.

### WATER SUPPLIES.

23. The provision of a safe water supply should receive the highest possible priority from the administration responsible for the welfare of its people. This has been recognised by every civilised country in the world. Many have yet to fulfil adequately their responsibility in this connection but few have as much leeway to make up as the Governments in India. The provision of a safe and adequate water supply is a basic requirement, the importance of which cannot be over-emphasised, and this remark applies with special reference to a tropical country like India which is subject to epidemic waves of water-borne diseases of great magnitude.

24. The percentage of population, urban and rural served by protected water supplies is 6·6 in Madras, 7·3 in Bengal, 4·1 in the United Provinces and 9·0 in the North-West Frontier Province. In Orissa there are only two towns in which protected water supplies have been provided while, in Sind, there are five. In the Punjab the percentage of population served with protected water supplies is 57·5 in urban areas but, in the rural areas of this province, the proportion is only 0·8 per cent.

#### Urban Protected Water Supplies

25. The majority of the urban areas do not enjoy the benefit of safe water supplies. It is only the larger towns and cities which possess them. In these towns the supply is usually intermittent while the quantity per head per day varies from 2 to 25 gallons. Calcutta is unique in that there are two water supplies, one of treated water and the other of untreated. Many of the urban supplies were designed some time ago and are quite out of date.



Some remained in the planning stage for 10 to 20 years and, by the time they were executed, were insufficient for the population for which they were designed.

26. It seems desirable at this stage to give some indication as to what may be considered an adequate supply of water for a municipal community. Obviously this must vary with the type of population concerned. Thus, in an industrial town, more water should be supplied than in a largely residential city. In Western countries the average overall quantity which is considered essential for domestic purposes is 25 gallons per head per day, but larger quantities are consumed in many towns, particularly in the United States of America. As a general principle it seems reasonable to state that for most towns in India, other than the more highly industrialised cities, a supply of about 35 gallons per head per day would be adequate considering the variations in climate over the whole year. This quantity will have to be increased considerably for large industrial cities such as Ahmedabad, Cawnpore, Calcutta, etc. For these a figure of 60 gallons per head per day would not be unreasonable.

27. Calcutta, Madras, Bombay and Poona maintain laboratories for the examination of piped water supplies, while arrangements have been made in the United Provinces for the testing of samples of water from five of the largest towns in that province. Methods of purification of water vary. In most of the older water supplies slow sand filtration is employed, a system which has not been satisfactory in operation largely because these filters have been badly maintained and operated. Rapid sand filtration has been installed in several cases—Hyderabad, Cawnpore, Agra, Lucknow, Allahabad, Calcutta and Madras—and this method is gaining popularity.

28. The initiative lies on the local body concerned to press for a protected water supply. The Provincial Government, on receiving a request for technical and financial assistance from a local body, directs its Sanitary Engineer to investigate and put up estimates for a water supply scheme. If these are accepted by the local body and if it agrees to find its share of the capital cost and maintenance charges from its own resources, Government makes a grant-in-aid which varies in the provinces from 33 per cent. to 50 per cent. Government may even advance the share of the local body as a loan. The actual construction is then carried out under the supervision of an Engineer of the Public Works Department and, on completion, the works are handed over to the local body. This passive attitude on the part of Government and lack of initiative on the part of local bodies have played a large part in making the development of protected water supplies extremely slow in this country.

29. Two other matters relating to urban water supplies require mention. One is the common practice in municipalities of permitting a large waste of water through failure to instal meters for regulating supply. We recognise that the poorer sections of the population should receive adequate supplies without having to pay for them. Even after making due allowance for this, we are

convinced that there is ample room for controlling waste through the installation of meters in appropriate places. The other is the general practice of diverting any profits which may accrue from water to the general funds of the municipality instead of earmarking even a portion of the amount for improvements to plants or to the augmentation of the supply.

### **Rural Water Supplies**

30. The source of supply is mostly from wells, tanks, rivers and streams and these are generally unprotected. Until quite recently (approximately 1930) very little attention was paid to this problem by the Governments in the country. Comparatively recently a Fund has been created to deal with this problem in some provinces. Bengal, for example, spent nearly Rs. 50 lakhs in tube wells in rural areas with the idea of combating cholera but left their maintenance to local bodies. The result is, we understand, that some 50 per cent. of these tube wells need major repairs, while 20 per cent. are completely derelict. In 1937 the Government of Madras formulated a comprehensive scheme of development for rural water supplies and constituted a Rural Water Supply Fund to which yearly contributions were to be made. A comprehensive ten-year plan was worked out but, unfortunately, before it was brought into operation the outbreak of the war put a stop to its progress. It is to be hoped that this important subject will receive early consideration in this province during the post-war period.

31. The importance of establishing an all-India body to deal with water conservation over the country as a whole and to recommend to the authorities concerned an equitable distribution of water among the different provinces was stressed by a number of persons. These include the Superintending Engineer of the Public Health Department of the United Provinces, Dr. Gilbert Fowler, the Chief Engineer, Calcutta Corporation and the Professor of Public Health Engineering in the All-India Institute of Hygiene and Public Health, Calcutta. Of these the first drew special attention to the disastrous effects of the unregulated depletion of the waters of the Junna and the Ganges by the Irrigation Departments of the Punjab and the United Provinces. As a consequence, the water supply of Agra and Cawnpore has been seriously affected during the summer months, while the river pollution problems resulting from the discharge of trade waste into these rivers have become aggravated.

## **GENERAL SANITATION.**

### **Disposal of Nightsoil**

32. We shall consider, along with the collection and disposal of nightsoil, the collection and disposal of sewage. The history of sanitary developments in Western countries shows that it was agitation for the provision of pure water and proper disposal of excreta which led to the general improvements now achieved. The first town in India to have an underground sewage disposal system was Calcutta, it having been introduced as far back as 1870. In spite of this early start, the development of the sewerage system in

India has been very slow, even slower than the provision of protected water supplies. Broadly speaking, the collection and disposal of excreta is a service confined to municipal towns only and by no means to all of them. For a number of even the larger urban cities, this service is at present of a low standard. Nightsoil is removed, in such towns in certain provinces, in baskets by "customary sweepers" and deposited along with other rubbish in "dalaos" or enclosures situated in public places. These "dalaos" are cleared later and the nightsoil is transported in special carts for the purpose. Sometimes these carts are in bad repair and leak on the road. The "dalaos" are, of course, magnificent breeding grounds for flies and the result is that all establishments in their immediate vicinity are under constant threat from these noxious insects. The actual disposal of nightsoil is generally by trenching which, in few municipalities, receives adequate supervision. Repair shops for nightsoil carts are maintained at Calcutta, Bombay, Madras, Madura, Delhi and other large cities, but there are numerous municipalities which do not maintain this elementary service. Composting has been tried of recent years in some towns and considerable progress has been made with this method of disposal, particularly in Madras. Where it can be and is practised properly, it is a process which reduces fly breeding considerably and results in valuable manure the use of which by local farmers can be slowly popularised.

33. Even in those towns which are provided with sewers it by no means follows that all the latrines are connected to the sewers. In such places, among which we may quote Madras, Calcutta, Dacca, Lucknow, Hyderabad (Deccan), the system is that nightsoil is collected in carts from areas not connected with the sewers and dumped into the sewers at places known as 'pail depots'. In the municipal areas of Agra, Lucknow, Cawnpore, Allahabad, all in the United Provinces, no conservancy tax is levied except on people living in the Civil Lines and these local authorities do not seem to consider it their duty to collect nightsoil from untaxed houses, with the result that the service which such houses receive is of a very low standard. In most provinces the number of public latrines in municipal areas is far too small for the needs of the population. In most municipalities the collection and disposal of nightsoil is a duty of the Health Department though, in some, the responsibility is laid on the Engineering Department.

34. Before we leave this subject of excreta disposal in towns we may give, for a few provinces, the number of sewered towns that exist. In Madras there are three, in the United Provinces five, in Bengal eight, in the Central Provinces one and in Bihar two. The total population living in areas normally served by sewers is probably only 7 millions. There are indeed many cities of over 100,000 population without this elementary amenity and, even where the underground system exists, it often serves only limited sections of the population. For example in Allahabad the Civil Lines are not sewered at all and in the main city a large proportion of the houses is not connected with sewers. In Dacca a

sewerage system, which was designed for a population of 45,000, has not been remodelled for the present population of 250,000.

35. The methods of disposal of sewage vary. Sewage farming is practised in the sewered cities of the United Provinces, Poona, Karachi, Mysore and some other cities and, on the whole, the system has been working satisfactorily. The 'activated sludge' process is in use in Delhi, Jamshedpur and a few other places. Bombay has an up to date modern treatment plant for a part of the city. The cities of Bombay and Madras dump a part of their sewage into the sea but the outfalls are badly located.

36. Nowhere have standards been developed for the quality of sewage effluents which can be safely discharged into natural waters. In Bengal septic tank effluents are required by law to be sterilised before being discharged into rivers. There is a Septic Tank Inspector in the Public Health Department, who collects samples of sewage effluent once a year in order to see that the law is enforced. Such inspections naturally fail to produce any material improvement.

37. In rural areas, with the exception of a few demonstration centres set up by certain Public Health Departments, it may be stated as a broad generalisation that no system of collection and disposal of excreta exists. In certain Panchayat and Union Board areas a small number of latrines of a primitive type are provided. Even in many municipal areas varying proportions of existing houses have no latrines and new houses are permitted to be built without latrines by the local authorities concerned. These general remarks must be qualified by the statement that limited attempts have been made in certain areas to promote proper nightsoil conservancy. Probably the largest advance has been made in the province of Madras. Here the rural sanitation unit attached to the Public Health Department has been promoting the development of the water carriage system in rural areas. Septic tank latrines have been built for individual houses, with a cheap type of concrete-seat with a water seal. Attempts have also been made to popularise hand-flushed public latrines on the water carriage system in some rural areas. In this province and in some other parts of India the popularisation of bore-hole latrines has also been attempted.

#### **The Collection and Disposal of Household Refuse**

38. *Urban Areas.*—A common practice in many municipalities in this country is to entrust the collection and disposal of refuse to contractors. The results have not been satisfactory as contractors are mainly concerned with making their profit and not with efficient service in the interests of the health of the community.

39. The actual methods which are in use for the collection of household refuse vary considerably. Public dust bins of varying patterns and efficiency are placed in the streets, often in inadequate numbers, and the householder is expected to deposit in them his household waste. It is only in two or three municipalities that household bins are in use. The contents of the dust bins are emptied into carts and taken away for disposal usually by dumping on land and, in a relatively small number of cases, by incineration. If this system is to be efficient it must be carefully

supervised and controlled. The public bins should be fly-proof and should be emptied of their contents as soon as they become full. These requirements are not met and street bins generally become fly-breeding centres and the happy hunting grounds of pariah dogs. If the transportation carts are not maintained in good repair and are not of a type which permits of the rapid emptying of the bin into the cart and the closure of the cart immediately afterwards, they too become a source of considerable nuisance. Under existing conditions of supervision and control such desirable standards of efficient service are not generally attained.

40. It must be remembered that the general lack of ordinary sanitary conveniences in all the smaller municipalities results in there being present in household waste a varying proportion of nightsoil and the consequence is that the danger to the public health from such collections of refuse is all the greater.

41. Incineration as a method of disposal of household refuse is not practised by most local bodies, probably because of the idea that refuse provides a useful means of filling up and reclaiming low-lying areas. Such reclamation is certainly desirable but the rubbish dumped in must be carefully covered over with sufficient earth to prevent fly-breeding and to permit of decomposition without causing nuisance. The requisite care is not, however, bestowed on this system of disposal with the result that fly-breeding is a common occurrence.

42. There are many municipalities which do not even levy a scavenging tax to cover the cost of a nightsoil and rubbish conservancy service and conditions in these towns are extremely unsatisfactory.

43. *Rural Areas.*—In rural areas no attempt has, on the whole, been made for the collection and disposal of household refuse. In some villages stable refuse is collected and, along with the household refuse, is piled in a backyard to be used subsequently as manure. The presence of nightsoil in such refuse renders the danger to health from such practice all the greater.

44. The lack of scavenging services in rural areas has perhaps helped to popularise bore-hole latrines, but the progress made in this direction has been limited. There are, of course, many places in which bore-hole latrines are not practicable, but large areas exist in which they can and should be developed.

#### **The Disposal of Industrial Wastes**

45. This is an important subject which has so far received very little attention. The unsatisfactory disposal of such wastes affects directly, in many cases, the amenities of a neighbourhood. Where an industry is situated on a river, the pollution which results from the disposal of untreated industrial waste into the river can have a profound effect on the use of its water. Owing to the haphazard manner in which industries have been permitted to grow up in urban areas in different parts of the country, much nuisance has been created by the inadequate disposal of waste products from various types of industries. Their adequate control is a matter of importance and urgency.

## CHAPTER XI

### QUARANTINE, INTERNATIONAL AND INTERNAL

#### Introduction

1. The idea that certain diseases spread by association with patients and that defilement from contact with them required purification of the person and disinfection of garments and houses dates back to many centuries before the Christian era in Egypt, India and the East generally. Evidence of this is available from the hygienic code incorporated in the Mosaic Law and from certain practices relating to personal and community hygiene enjoined by religious custom in India and adopted by many sections of the Hindus even to-day. But the practice of quarantine seems to have become a recognised measure against the introduction of diseases only in the 14th century. It was first introduced against plague as will be seen from the following quotation from Sir George Newman's book, "The Rise of Preventive Medicine".

"When it became obvious to all concerned that plague passed from port to port, and was thus conveyed from the Levant to the coasts of other countries, the great maritime powers introduced a system of quarantine, an initiation of an international sanitary cordon. Venice, the Queen of the Adriatic, began in 1374, and its practice was quickly followed at Ragusa on the Dalmatian coast in 1377 and at Marseilles in 1383. Incoming ships and passengers from the East were trentined and quarantined for thirty or forty days respectively. The ships were opened to sun and wind, and were also fumigated. A hundred years later Venice set apart special sanitary officers at ports to ensure effective quarantine practice."

#### International Measures to Prevent the Spread of certain Communicable Diseases

2. International measures to prevent the spread of communicable diseases are regulated by two international sanitary conventions relating to sea and air traffic respectively. They are:—

- (1) The convention signed at Paris on the 21st June 1926 which relates to sea traffic and
- (2) The convention for aerial navigation concluded at the Hague on the 12th April 1933.

These two conventions prescribe that the governments which have accepted them should take action on certain prescribed lines in regard to (1) the communication of epidemiological information regarding their own territories, (2) the export of infection from their sea and air ports and (3) the imposition of quarantine and other measures against persons and goods arriving by sea or air in their territories from infected areas in other countries. An international organisation, the Office International d'Hygiene Publique at Paris, on which the Governments of over fifty countries were represented, was, till 1940, the institution responsible for the formulation of these conventions and for the supervision of their operation. Its Permanent Committee used to meet twice a year to consider quarantine matters of international importance and to make suitable recommendations for adoption by all the participating countries.

### **The Dissemination of Epidemiological Intelligence**

3. Under the 1926 convention each Government is required to notify to other Governments and to the Office International d'Hygiène Publique at Paris—

- (a) the first recognised case of plague, cholera, or yellow fever in any locality within its territory;
- (b) an extension of any of these diseases from areas already affected to other areas and
- (c) the incidence of typhus or smallpox in an epidemic form.

Such notifications are to be followed up by subsequent communications furnished regularly to the Office at Paris so that other Governments may be notified of the course of an epidemic. The infectious diseases recognised for the purposes of the International Aerial Sanitary Convention are also the same.

4. In order to facilitate the dissemination of epidemiological intelligence among the participating countries, the conventions have authorised the Office International at Paris to collaborate with other international organisations concerned with the collection and distribution of such information. The Office was therefore working, in this field, in close association with the Health Organisation of the League of Nations and the Pan-American Sanitary Bureau. Under Article 23 of the Convention of the League of Nations it was provided that States, which were members of the League, should endeavour to take steps in matters of international concern for the prevention and control of infectious diseases. One of the steps taken by the Health Organisation of the League in this connection was the setting up of an epidemiological intelligence service, which consisted of a central organisation at Geneva and of regional bureaux at Alexandria for the Middle East and at Singapore for the Far East. This latter bureau was established in 1925 and collected weekly information from the health authorities of all countries east of Suez and broadcast it from Saigon in French Indo-China and from Malabar in Java for the benefit of ships and of health authorities of the participating countries. To this bureau was sent from India every Wednesday by the Public Health Commissioner, information relating to the incidence of the common infectious diseases, cholera, smallpox and plague. These figures along with similar information collected from other countries were compiled at Singapore and cabled to the Geneva office for transmission to the Office International in Paris.

5. The Pan-American Sanitary Bureau has a permanent executive board with its headquarters in Washington and its functions include, among others, the collection and distribution of information on health matters.

6. As pilgrimages can play a large part in the spread of infectious diseases, elaborate provisions have been made in the International Sanitary Convention, 1926, for the supervision of the health and comfort of pilgrims as well as for the enforcement of such measures as will minimise the possibility of the spread of these diseases. For instance, standards have been laid down for pilgrim ships in:

respect of the floor space for individuals, ventilation, the provision of sanitary convenience, cooking arrangements, the provision of wholesome food, water and medical facilities, including the employment of a qualified doctor and the provision of hospital accommodation and the necessary medicaments, disinfectants, vaccines, etc. Vaccination against smallpox and other diseases can be enforced before the pilgrims leave their country, if the necessity for such a measure exists, and there is also provision for health supervision on the onward and return journeys.

### **Prevention of the Export of Infection from a Country**

7. The provisions included in these conventions to control the export of infection from a country are (1) the prevention, by means of a medical examination, of the embarkation by sea or air of persons suffering from any of the five diseases mentioned above and "of persons in such relation with the sick as to render them liable to transmit the infection of these diseases", and (2) the carrying out of such special measures as may be required in respect of each of these diseases, *e.g.*, the prevention of rats gaining access to ships or aircraft as regards plague, the protection of food and water on ships in respect of cholera and the delousing of suspects before embarkation to prevent the spread of typhus.

### **Prevention of the Entry of Infection into a Country**

8. To prevent the entry of infection into countries instructions have been laid down in the conventions detailing the conditions under which a ship or an aircraft should be declared as 'healthy, infected or suspected' and the measures to be taken in each case. In addition, each Government is required to make special provision in its larger sea and air ports for an organised health service, which is able to provide medical supervision over the health of the crews of the ships visiting the port and to carry out the preventive measures necessary to prevent the entry of infection into the country, including the transport of patients and their isolation and treatment.

### **Quarantine Practice in India**

9. The Government of India has not yet ratified these International Sanitary Conventions but it has attempted to carry out, even before ratification, many of the obligations imposed by them. One of the reasons why the Government of India had not ratified either of these conventions was that it was first necessary for them to introduce new Indian Port Health Rules and New Indian Aircraft (Public Health) Rules in order to incorporate therein the measures prescribed in the conventions and to set up adequate health organisations at the major seaports and airports in the country. The Indian Port Health Rules were published in 1938 and the Indian Aircraft (Public Health) Rules in 1940. India has seven major seaports and 26 minor ports, from which sea-going traffic proceeds to foreign ports. The major ports are all under the administration of the Government of India, while the minor ports are administered by Provincial Governments as agents of the



a minute. The inadequacy of the number of doctors employed is, therefore, evident. In addition, the medical officers in charge of many dispensaries have, for long periods, been out of touch with modern medical practice without an opportunity to work in a well conducted hospital, such as the better class institutions located at the headquarters of districts. The quality of the medical aid given by such men must necessarily be low. Other defects include unsatisfactory conditions in regard to the design of, and accommodation in, medical institutions, considerable overcrowding in the wards and grave insufficiency of the nursing staff.

20. We also desire to draw attention to the grave difficulties to which the poorer classes are put in securing medical aid at public hospitals and dispensaries. They frequently come from considerable distances and may have to spend a whole morning before they are seen by the doctor. The sympathetic attention and courtesy which they are entitled to expect from the hospital staff are often absent. We recognise that the great insufficiency of existing staff may, in part, explain this, but we feel bound to draw the attention of the authorities concerned to these defects in the administration of medical institutions in the interests of ensuring a better standard of service to the people. All the steps that are necessary to remove these defects should be taken without delay. Apart from the fact that the poorer sections of the community have the right to demand fair treatment at the hands of the hospital staff, we feel that the one condition which we have stressed for ensuring the success of the future health programme, namely, the active support and co-operation of the people in the day-to-day functioning of the organisation, cannot be fulfilled without a radical change in the existing state of affairs.

21. The number of beds available in British India, including those for the treatment of general and special diseases, is about 73,000 or about 1 bed to 4,000 of the population. The following figures compare British India with England and Wales and the United States of America in this respect:—

U.S.A.	10.48	beds per 1,000 population.
England and Wales	7.14	„ „ 1,000 „
British India	0.24	„ „ 1,000 „

22. The question may be considered from another point of view. In England it has been estimated that, with the existing morbidity and mortality rates, the minimum standards should be 10 beds per 1,000 of the population. On this basis the number of beds required for India will be over 40 times the present provision. When it is remembered that the mortality rate in England is only half that of India and that the morbidity rate in the latter is, therefore, bound to be much higher than in England, adequate institutional care would seem to require an expansion of hospital accommodation which may well be about 80 or 90 times the present provision.

23. Some idea of what can be achieved in increasing hospital accommodation can be obtained from what has been done in Soviet Russia within a period of about a quarter of a century. In 1914

Government of India. The major air ports in the country are at Karachi and Calcutta, in both of which there are multiple land air ports as well as marine ports for flying boats.

### **Special Measures against the Introduction of Yellow Fever**

10. The subject of international quarantine has particular importance to India on account of the risk of the introduction of yellow fever. Special measures have been taken to protect against this eventuality and they include, among others, the maintenance, for the immunisation of the people against the disease, of ample stocks of yellow fever vaccine which were made available to the Government of India by the courtesy of the Rockefeller Foundation, New York; the provision of facilities for this vaccination at Bombay, Karachi, Calcutta, Madras, Kasauli and New Delhi; the drawing up of a mobilisation plan to cope with any possible outbreak of the disease and the maintenance of adequate stocks of all necessary materials such as sprayers, pyrethrum extract, etc., for immediate use in any place in India at short notice. The Government of India is advised on the technical aspects of this problem by the Public Health Commissioner who has the assistance of a Yellow Fever Committee, which was brought into being in December 1939 and which has maintained close contact with a similar committee which sits in London to consider the problem from the point of view of inter-Commonwealth traffic.

### **Quarantine Measures along India's Land Frontiers**

11. Control of the spread of infection through land routes can, on occasions, become a matter of the greatest importance as, for instance, at the end of the first World War (1914-18) when large scale epidemics of typhus and relapsing fever threatened to sweep across Europe from Russia. In India land quarantine has so far been restricted to special occasions which have been infrequent. In March 1943 following an outbreak of typhus in Afghanistan, inspection stations for the delousing and segregation of persons were set up along the main routes entering the North-West Frontier Province and Baluchistan. On certain occasions the Government of Afghanistan prohibited, in the past, the entry of persons, who were not protected against cholera by inoculation, into that country from British India.

### **Internal Quarantine**

12. The purpose of internal quarantine measures is to prevent the spread of infectious disease from one administrative unit in the country to another. Any scheme designed to achieve this end should ensure adequate control over the spread of infection between neighbouring Provinces and between the Provinces and the Indian States which lie adjacent to them. No attempt has so far been made to deal with this problem in a comprehensive manner and no organisation exists for the coordination of such preventive measures as individual Provinces and States may carry out in their own territories. In recent years, however, there have been some

developments in connection with preventive measures against epidemics following in the wake of fairs and festivals. Great numbers of these are held at various places throughout India and are attended by people from distant parts of the country. In the past extensive outbreaks of cholera have been associated with some of these festivals. The Government of Bombay led the way in attempting to control the spread of the disease by introducing an indirect form of compulsory inoculation of pilgrims attending the large festivals held at Pandharpur in that province. The enforcement of this measure received considerable support from the authorities of the neighbouring State of Hyderabad (Deccan) and of the Central Provinces and Berar, from both of which large numbers of pilgrims attend the Pandharpur festival. This commendable example has been copied and improved upon elsewhere, and in Bihar, Orissa, Sind and recently in the United Provinces, compulsory anti-cholera inoculation of pilgrims attending important festivals in these provinces was carried out with the active cooperation of different health authorities.

13. *The legal position.*—Under the Government of India Act, 1935, the prevention of extension from one unit of the Federation to another of infectious or contagious diseases or pests affecting men, animals or plants is an item under Part II of the Concurrent Legislative List, so that both the Central and Provincial Legislatures have power to enact laws. The Central Government can give directions to a Province regarding the carrying out, in that Province, of any Central Act relating to the subject, provided the Act authorises the giving of such directions. The actual execution of the necessary measures is a function of the Provincial Government. Failure on the part of a Provincial Government to give effect to any directions given by the Central Government can be rectified by the Governor-General, acting in his discretion, issuing as orders to the Provincial Government either the directions previously given or those directions modified in such manner as the Governor-General thinks proper.

14. When Federation comes into being, the Federal Legislature will have power to make laws on this item under Part II of the Concurrent List in respect of a State which enters the Federation and accepts this item as a matter in which the Federal Legislature can make laws. This power will be subject to such limitations as may have been specified in the Instrument of Accession of the State concerned. Limitations can also be placed on the executive authority to be exercised by the Federation.

15. The power provided for the intervention of the Governor-General in his discretion appears to be capable of promoting a type only of such a dilatory nature as to be of little use for the solution of the urgent problems requiring immediate attention, which national quarantine administration may bring up from time to time. As regards the States, the limitations which may be imposed by the provisions of individual Instruments of Accession in respect of federal legislation and executive action may restrict, even to a greater extent than in the case of the Provinces, the powers of the

Centre to enforce quarantine measures. The existing legal position and the limitations it imposes on the organisation of an effective system of internal quarantine will have to be taken account of in formulating our proposals for the control of the inter-provincial spread of communicable diseases. The United States of America afford certain valuable suggestions in this connection and we shall refer to them when we discuss the subject of quarantine in Volume II of this report, which deals with our recommendations.



## CHAPTER XII

### VITAL STATISTICS

1. Vital statistics form the foundation of all planned health work. "As ultimately preventive and curative work must be organised on the basis of accurate knowledge of the diseases and disabilities in an area, the importance of collecting accurate vital statistics cannot be over-emphasised."\* Both the Royal Commission on Agriculture and the Royal Commission on Labour drew attention to various defects in Indian vital statistics and stressed the importance of effecting an early improvement.

2. The term vital statistics can, in its wider sense, include information relating to a wide range of human activities, but it is usually applied to a narrower field covering births, deaths, marriages and the incidence of disease in the community. In India registration of marriage does not take place among the two communities, the Hindus and Mohammadans, who together form over 90 per cent. of the total population. Such statistics as may exist in this country for marriages can therefore relate only to a small section of the population and we shall not therefore refer to them here. We shall confine ourselves to the statistics of births, deaths and morbidity. As regards the last, no country can claim reasonably accurate statistics for the population as a whole, except in the case of certain diseases which are made notifiable by law. In India the available statistics in respect of births, deaths and notifiable diseases are all defective. Such defects are associated partly with the registration of these vital events and partly with their compilation. Before we deal with these defects it may be of advantage to describe briefly the agencies employed in different parts of the country for the registration and compilation of vital statistics.

#### **Agencies for Registration and Methods of Compilation†**

3. In towns and cities the municipal authority is responsible for the registration of vital statistics and this function is usually a part of the duties of the health department. In the rural areas the village watchman or the *chowkidar* is usually the reporting agent. In Northern India generally, the registrar is the officer in charge of the *thana* or police station, while in the province of Madras the village headman is the registrar. In those provinces in which the registrar is the police station officer, births and deaths from the different villages constituting a *thana* are registered on specific days of each month, when the *chowkidar* is required to report himself at the police station. The interval between such visits of the *chowkidar* is in some areas a week and in others a fortnight. In areas where the village headman is the registrar, the recording of these events takes place more promptly.

4. As regards infectious diseases, it is understood that, in certain provinces, an outbreak of any of the common infectious diseases has to be reported by the village *chowkidar* immediately to the

\* Report of the Inter-governmental Conference on Rural Hygiene held in Java in 1937 under the auspices of the League of Nations.

† Most of the information given under this head and in this chapter generally is taken from the "Memorandum on Indian Vital Statistics" which is incorporated in the Second Report of the Central Advisory Board of Health (1939).

police station concerned, although subsequent events are brought to notice only on the days on which he is required to visit the *thana* headquarters in connection with his routine duties. In the province of Madras, daily reports are required to be sent, it is understood, by the village headmen throughout the course of an epidemic.

5. The procedure in regard to the compilation of vital statistics differs to some extent in the provinces. In Bengal, for instance, the figures for the different rural *thanas* in a sub-division are compiled in the office of the Sub-divisional Officer and then passed on to the District Health Officer who, after including those for municipalities, which he receives direct, submits the figures to the Director of Public Health. In those provinces in which a public health organisation has not been built up in the districts, the Civil Surgeon is responsible for the compilation of the statistics for the district as a whole and for their submission to the Director of Public Health. The province of Bombay, which belongs to this category, is an exception. Here returns from municipalities and *talukas* are submitted to the Assistant Director of Public Health of the range concerned and he sends a consolidated return for his range to the Director of Public Health. In the province of Madras the compilation of all the returns from individual villages has been centralised in the office of the Director of Public Health, the return from each village passing, through the Tahsildar of the *taluk*, to the Director of Public Health. It has been the experience that the chances of errors in compilation become greater when the number of intermediate stages of compilation is increased.

### Defects in Registration

6. These are mainly:—

- (1) omission to register appreciable numbers of births, deaths and cases of notifiable diseases and
- (2) incorrectness of the recorded cause of death.

7. *Incompleteness of registration.*—Some idea of the extent of error, for the country as a whole, through incompleteness of registration may be obtained from a comparison of the recorded birth and death rates for British India and those derived by what is known as the "Reverse survival" method, which has been described in the chapter dealing with the population problem in Volume II of this report.

#### *British India.*

Period	Birth rate		Death rate	
	Recorded rate	Estimated rate (Reverse survival method)	Recorded rate	Estimated rate (Reverse survival method)
1891—1901	33	46	31	44
1901—1911	37	49	33	43
1911—1921	37	48	34	47
1921—1931	33	46	25	36
1931—1941	34	45	23	31

The differences between the birth and death rates based on the registered figures and those obtained by the reverse survival method are appreciable in respect of every decade.

8. One of the causes for such incompleteness of registration is that, over large areas in the country, registration of births and deaths is not compulsory. Further, as has been pointed out in the Memorandum on Indian Vital Statistics, "even in those limited areas where registration is compulsory, the provisions of the Acts are rarely enforced, so that generally speaking vital statistics are deplorably defective". Another cause is that the village *chowkidar*, who is responsible for reporting these events in respect of the rural population, and the police, who are responsible for registration, are so over-burdened with other work that the tendency is to regard their duties in connection with vital statistics as of relatively smaller importance.

#### Incorrectness of the Registered Cause of Death

9. A reasonable degree of accuracy in the registered cause of death can be attained only by certification by a medical man who has had the opportunity of examining the patient before his death. The absence of an adequate health service to meet the requirements of the people and the fact that, for the rural areas as a whole, the reporting agent is the illiterate *chowkidar* together help to render the recorded causes of mortality of little value from the point of view of assessing public health conditions. No accurate estimate of the degree of error in these recorded causes of death can be given. The results of a scheme of verification of the cause of death in Delhi City carried out by the Medical Officer of Health during 1937 may, however, help to throw some light on this question. Of 9,660 deaths registered during the year, nearly 98 per cent. were enquired into by medical men and, from the history obtained, the probable causes of death were deduced. Obviously such a method is defective as compared with medical certification. Nevertheless, the "verified" cause of death is likely to give a greater measure of accuracy than the cause ordinarily registered. The following figures and the comments on them are quoted from the 1937 annual report of the Public Health Commissioner:—

	Notified and registered cause of death.	Verified cause of death.
1. Malarial fever . . . . .	5	236
2. Measles . . . . .	123	123
3. Smallpox . . . . .	575	575
4. Typhoid fever . . . . .	395	388
5. Diabetes . . . . .	10	13
6. Broncho-pneumonia . . . . .	6	2,252
7. Pneumonia . . . . .	1,035	568
8. Phthisis . . . . .	516	882
9. Puerperal fever . . . . .	1	50
10. Senile debility . . . . .	29	661
11. Infantile diarrhoea . . . . .	123	1,117
12. Premature birth . . . . .	5	194

"In some cases, the discrepancies are very large. The combined figures for pneumonias, for instance, show a difference of 1,779; infantile diarrhoea, premature births, phthisis and puerperal fever all show considerable variations, whilst for 'senile debility', the number recorded is no less than 632 in excess of the registered number. If the assumption is made that the "verified" causes of death give a greater measure of accuracy than the "notified and registered" causes, then the striking differences in numbers under such headings as pneumonia, puerperal fever, infantile diarrhoea and "premature birth" signify certain directions along which preventive measures should be taken."

In the absence of medical certification, even verification of the cause of death on the lines indicated above can be of great value from the point of view of health administration.

### **Errors of Compilation**

10. The Memorandum on Indian Vital Statistics has referred to an investigation carried out by the Madras Public Health Department some years ago, which revealed that, in one district, the monthly statistical return "contained figures only for 25-35 per cent. of the 1,664 villages included in that district". In that province, when the compilation of all returns from individual villages was centralised in the office of the Director of Public Health, a considerable improvement was recorded. Defaulters could be watched and appropriate action taken so as to ensure that the consolidated return for the province was made as complete as possible. We have already pointed out that the general experience has been that, with an increase in the intermediate stages of compilation, the chances of error creeping in become greater. In recognition of this, the Central Advisory Board recommended that other provinces should also adopt the centralised form of compilation which has been in operation in Madras.

### **Notifiable Diseases**

11. Our remarks in the preceding paragraphs regarding large omissions in the registration of births and deaths and errors in compilation apply also to notifiable diseases. The extent of error in regard to omission is, however, less in the case of the common epidemic diseases of cholera, smallpox and plague than in respect of other infectious diseases. This is due to the fact that the signs and symptoms of the former are generally known to the people. Although it will not be correct to claim even a reasonable approach to completeness of registration for these three diseases, the recorded figures for them give a fairly clear indication of their varying incidence from year to year. Such an assumption is not permissible in respect of other communicable diseases. Indeed, many of them can be diagnosed only if medical aid and laboratory facilities are available. Examples are tuberculosis, cerebrospinal fever, typhus, typhoid and relapsing fever. These are now notifiable in both rural and urban areas in a certain number of provinces. In the absence of the necessary facilities for proper diagnosis it seems certain that no reasonable proportion of the



actual occurrences of these diseases will be brought on record, while the correctness of the registered events under each disease is open to question. The number of communicable diseases, which are notifiable in the different provinces, varies considerably. For instance, the 1937 annual report of the Public Health Commissioner gives 22 for the Central Provinces, 20 for the Punjab and 7 for the North-West Frontier Province. The question of reducing the list of diseases notifiable in rural areas to the minimum possible and of increasing the number of such diseases in urban centres in proportion to the facilities for diagnosis which may be expected to be available will have to be considered when we put forward our proposals for the improvement of vital statistics.

12. To sum up, the main defects of the existing system of registration and compilation of vital statistics in India are:—

- (1) registration is not compulsory over large parts of the country;
- (2) even where registration is compulsory, failure to enforce the law against defaulters has resulted in no material improvement being effected in such areas;
- (3) omission to register births, deaths and cases of notifiable diseases is appreciable in all parts of the country, a contributory factor being that the duties to be performed by village *chowkidars* and police officials in regard to vital statistics are not adequately discharged because of other important duties they have to attend to;
- (4) gross inaccuracy in the registered causes of mortality in the absence of medical certification of death;
- (5) large omissions in the recorded incidence of notifiable diseases and incorrectness in their diagnosis, mainly owing to the fact that many such diseases have been made notifiable in areas where no proper facilities for their diagnosis exist and
- (6) errors in compilation, probably assisted by the fact that, in certain provinces, this work is carried out at a number of administrative levels.

## CHAPTER XIII

### PROFESSIONAL EDUCATION

1. We shall deal with professional education in the field of health under the following heads:—

- (1) Medical education.
- (2) Dental education.
- (3) Nursing education.
- (4) The training of certain types of public health personnel.
- (5) Pharmaceutical education.
- (6) The training of technicians.
- (7) The training of hospital social workers.

### MEDICAL EDUCATION

2. Under this head we shall consider the facilities available for the training of undergraduates and of medical licentiates, for postgraduate education and for refresher courses

#### Undergraduate Training

3. Undergraduate training is given in colleges affiliated to universities and the preliminary educational qualifications for entrance to such colleges is an Intermediate in Science or a qualification recognised as equivalent. The preliminary qualifications required, the period of study, the subjects of study, and the examinations to be held are governed by certain general instructions issued by the All-India Medical Council, which has the power to lay down the minimum standards required.

4. *Admission to medical colleges.*—There are, in India, some 19 medical colleges which include two in Indian States (Mysore and Hyderabad) and a special college at Delhi for women students only. The other colleges are located in the provinces of Madras, Bombay, Central Provinces and Berar, Bengal, the United Provinces, the Punjab, Bihar and Orissa which is a recent addition. The total number of students admitted into these colleges each year is about 1,200. For a population of 400 millions the annual intake of 1,200 students for medical training is definitely low. In some places the authorities concerned have laid down conditions regarding the community, residential qualification, etc., of the candidates to be admitted to the colleges and selection committees have been appointed to choose the applicants after taking into consideration all these conditions.

5. *Course of study.*—The course of study extends, in the majority of medical colleges, over a period of five years. A six months' preliminary Pre-Registration course is, however, insisted upon before the commencement of the regular medical course in the Madras, Andhra and Mysore Universities, partly because the Intermediate in Science examination in these Universities does not provide a practical test and partly because it is considered that a

vocational bias in the teaching of the subjects of physics, chemistry and biology is desirable.

6. *Pre-clinical Training.*—The teaching of the basic medical sciences of Anatomy and Physiology covers generally a period of two academic years. Our criticisms regarding the existing training in these subjects are, broadly, (1) that too much detail is taught and is expected of the student, so that he gets lost in details and does not acquire a sound knowledge of the fundamental facts; (2) that the practical application of these subjects to later studies in clinical subjects is not brought home to the student; (3) that the transition from pre-clinical to clinical studies is abrupt; and (4) that the student in the period of clinical training does not have applied anatomy and applied physiology taught to him by his pre-clinical professors.

7. A deficiency, which is noticeable in practically all the medical colleges in the country, is that the teaching of the pre-clinical subjects has not been organised in an atmosphere of research, with the result that the student's powers of observation and of drawing deductions from such observation are not adequately stimulated.

8. As regards Anatomy, a disproportionately large amount of the total period devoted to the medical course appears to be spent in this country on the teaching of this subject as compared with the practice in countries in which medical education is on more progressive lines. For instance, in the King Edward Medical College, Lahore, the subject appropriates to itself 1,274 hours out of a total of 4,546 for the entire medical curriculum and, in the Andhra University, 1,124 hours out of 4,158. At Harvard, on the other hand, the corresponding periods are 480 hours out of 4,000 and in Russia 438 out of 5,760 hours. It is believed that the time taken up by lectures and demonstrations and by dissection can be curtailed to an appreciable extent, if the existing staff can be increased sufficiently to enable individual attention to be given to the students and to have the training developed, to a large extent, on the lines of tutorial classes.

9. The teaching of Physiology is mainly didactic. The teaching of experimental Physiology does not come up to the standard of even the average medical school in the United Kingdom. In several colleges biochemistry is taught by the Professor of Physiology, while in other countries it is given the status of a separate professorship.

10. The teaching of Pharmacology is also imparted mostly through lectures. In the country as a whole, arrangements and equipment for experimental pharmacology are of a low standard. Pharmacy claims a disproportionately small period of time in the practical classes. There is but little liaison between the departments of medicine and pharmacology in the imparting of instruction in applied pharmacology and therapeutics.

11. *Clinical training.*—A survey of existing facilities for the clinical training of medical students reveals the fact that there is

the number of beds per 1,000 of population was 0.98. By 1940 it had risen to 4.66, an increase by over four and a half times.

24. As regards the preventive health organisation, a certain number of provinces have District Health Officers in charge of rural health administration in all their districts, some others have such officers only in a limited number of districts, while the remaining provinces have the Civil Surgeon in combined charge of medical and public health activities. The extent to which health officers have been appointed in municipalities also varies widely in the provinces. The total number of sanitary or health inspectors employed in British India is about 3,000 while it has been estimated that the number required will be in the neighbourhood of 12,000. The existing number of midwives is probably 5,000, while, for adequate service to the people, 100,000 are considered necessary. The total number of health visitors in the country is about 700 or 750 while, for the supervision of the work of 100,000 midwives about 20,000 health visitors will be required. The number of woman doctors with special training in maternity and child welfare work is about 70 or 80 and, of these, only a dozen are women graduates in medicine with adequate special training in maternity and child welfare work.

25. Thus it will be seen that the existing organisations for curative and preventive health work in India are altogether inadequate for the tasks with which they are confronted. On the medical side, the existing staffs are hardly able to do anything more than struggle with the large numbers of patients crowding into hospitals and dispensaries. On the public health side, the energies of the skeleton staff employed in the provinces have, so far, been concerned mainly with measures for the control of epidemic diseases, and even this task is being performed with insufficient results. A wide expansion of the curative and preventive health services should therefore form an important part of our programme of future health development in the country.

### **General Education and Health Education**

26. The purpose that general education has in view is to develop the individual into a useful citizen; the purpose of health education is to inculcate the principles of healthful living in order to secure the full co-operation of the individual in the maintenance of his own health. Without general education the task of imparting instruction in health matters becomes difficult. Apart from the handicap that illiteracy places on health education by restricting the methods of appeal to the spoken word or to visual demonstration, education in its wider sense is essential in order to promote a general raising of the standard of culture in the community and to quicken the sense of civic responsibility of the individual. The insanitary conditions associated with rural and urban life in the country can, to a large extent, be mitigated if the individual feels a sense of responsibility towards his neighbour. Speaking generally, while the Indian home is kept fairly clean, the sense of responsibility of the average person in regard to

considerable room for improvement. Certain points to which we desire to draw attention are:—

- (1) Too many didactic lectures are being given in the colleges with little benefit to the student.
- (2) There is imperfect correlation in the teaching of Pathology, Bacteriology, Hygiene, Medicine and Surgery. As a consequence there is repetition of the same theme, possible divergence in the methods of teaching and waste of time and energy.
- (3) Further, there is little or no coordination and planning in clinical instruction among the different clinical teachers of a department (medicine, surgery or obstetrics and gynaecology), so that the student, who passes from one clinical teacher to another, is not infrequently treated to a repetition of the same topics.
- (4) The proper selection of cases suitable for undergraduate teaching and the availability of such cases at the proper time are not being given adequate consideration in admitting cases to the teaching hospital. Instead of a variety of cases of primary importance to the general practitioner being available, not infrequently rare and complicated cases are permitted to fill the wards, the study of which, though of doubtless interest to the specialist, is not suited to the requirements of the undergraduate.
- (5) The teaching in the out-patient department is deplorably deficient in many institutions. The overcrowded, insanitary and noisy surroundings which exist cannot provide the atmosphere necessary for proper clinical teaching.
- (6) The emphasis laid on the teaching of preventive medicine and public health in the medical student's undergraduate course is quite inadequate. We recognise that, in other countries also, although considerable lip service has been paid to the importance of inculcating the idea of prevention in the student throughout the medical course, very little advance has been made in the organisation of a programme of training fulfilling this purpose. In India the way in which the subject is taught is such as to encourage the student to consider it as of little importance and of less interest. Details about such matters as water supply, sewerage systems and vital statistics and their calculation make the course dull and uninteresting. As far as we are aware, in no teaching institution are the practical and applied aspects of preventive medicine placed before the student in such a manner that he can assimilate them and appreciate fully their importance both to the individual and to the community. In the teaching of the subject the student can and should be brought into contact with those environmental and social conditions which largely influence

ill-health in the individual and in the community, and it is only by doing so that the medical student will be properly equipped for his future responsibilities as a doctor and as an adviser to the people in all matters relating to health. We shall take into consideration these requirements in the proposals we put forward for the reorganisation of undergraduate medical education.

The Professor of Public Health, where such a post exists—in many colleges there is only a lectureship in this subject—is frequently a member of a Government or other public health department. It seems to us that any public health official, who is burdened with departmental duties, cannot have sufficient time to perform the functions expected of a professor. Such an officer, in our opinion, is well fitted to give lectures and demonstrations to students on certain aspects of health work but that he should be made entirely responsible for education in this important field of medicine is an arrangement which we consider unsuitable.

- (7) In relation to the number of students to be catered for, the hospital facilities, the number of beds per student, more particularly in medicine and surgery, the number of clinical teachers available and the time devoted by them to teaching cannot be considered sufficient.

As regards the number of beds per student, the existing provision in certain colleges is shown below:—

	No. of beds per student.
Grant Medical College, Bombay . . . . .	5
Stanley Medical College, Madras . . . . .	9
King Edward Medical College, Lahore . . . . .	5
King George Medical College, Lucknow . . . . .	4
Carmichael Medical College, Calcutta . . . . .	5

We are advised that a ratio of 10 beds to each student is what is normally required.

As regards the teaching staff, a survey of the existing medical colleges has made it clear that the number of teachers, in most of them, is inadequate for the total number of students. Not all the universities have, as yet, prescribed necessary minimum qualifications for the teaching staff but the trend has been towards insisting on certain minimum qualifications. Usually a postgraduate degree, such as the M.D. or the M.S. or a similar qualification, is insisted upon for professors and lecturers. The University of Madras has prescribed in detail the qualifications required for the teaching staff in all subjects of study. In some provinces the professorial chairs are reserved for members of the Indian Medical Service or Provincial Medical Service. In other provinces the field of selection extends to others also. The age of retirement is fixed at 55 as far as Government colleges are concerned, but in private colleges no age limit has been laid down and there has, indeed, been a tendency

to recruit retired men from Government services. In one college the majority of the senior members of the staff are persons who have passed the age of 55 and some of them are as old as 60 and 65. In an institution where a large measure of personal attention and supervision of the work of the student is necessary, it is a disadvantage to have a number of professors who are advanced in age. Another factor making for inefficiency, which has been noted, is that the members of the staff are not often full-time teachers. Many of them are busy practitioners working in an honorary capacity. Others, though members of the public service, are permitted to take private practice and they therefore devote a considerable part of their time to it. In certain institutions part-time teachers are employed even in pre-clinical subjects and the right of private practice has been given to them too. It seems almost certain that such members of the teaching staff are not in a position to devote adequate time and attention to their teaching duties.

#### **Certain Other Matters**

12. *Laboratory facilities and equipment.*—Owing to the conditions brought about by the War, there has been a certain amount of difficulty for the different medical colleges to secure adequate stocks of equipment and laboratories have had to be run with a shortage of various chemicals and appliances. In some colleges, however, the equipment and laboratory facilities available to the students may be said to be adequate for the numbers under training. In others the existing accommodation and facilities require improvement.

13. *Museum.*—Museums are available in all the colleges, but there is room for enlarging their scope and improving their usefulness. Only a few museums are provided with curators.

14. *Library.*—In many colleges the library facilities available are not adequate either for the students or for the staff and the annual allotment for this purpose is far from sufficient in many institutions. No clear-cut distinction has been made between the library facilities available for the students and those for the staff. The number of periodicals provided for the members of the teaching staff is small and insufficient in certain colleges. We believe that a large outlay will be required in all institutions on the development of libraries, in order to enable the teachers to keep abreast of advancing knowledge and to provide facilities for research. None of the medical colleges at present possesses a trained librarian, with suitable assistants who are capable of preparing a proper index and of translating articles from foreign periodicals.

15. *Social amenities.*—Most medical colleges have facilities for recreation for their students and many of them provide hostel accommodation for a proportion of them. The provision of common rooms, dining halls and other facilities is not, however, adequate in all the colleges.

16. *Residential accommodation in hospitals.*—No proper accommodation for medical students who are expected to be in residence or to take duty in turn is available in the teaching hospitals.

### **The Technical Control of Undergraduate Medical Education**

17. As has already been pointed out, the Indian Medical Council has the right to inspect medical colleges and to suggest methods of improving the efficiency of the training given. Such inspections have been carried out within the last ten years after the inauguration of the Indian Medical Council and has led to the rectification, in a number of medical colleges, of defects that existed.

18. As these colleges are affiliated to universities, the latter can also exercise control by laying down conditions to satisfy the following requirements:—

- (i) The qualifications of the teaching staff and the number required in each subject.
- (ii) The accommodation required in the laboratories and the number of students that should be admitted.
- (iii) The hospital facilities available and the number of beds that should be at the disposal of each student for adequate clinical study.
- (iv) The amenities that should be available to the students in the shape of common rooms, reading rooms, playing fields, hostels, etc.
- (v) In general, the arrangements required in the college and associated hospitals in order to ensure that efficient instruction is being given to the students.

Some universities have been more strict in the control of the medical colleges under their charge than others. On the whole, we consider that there is need for more efficient supervision and control of academic standards in these colleges by the universities concerned. A university has the power to send periodically an inspection commission to report on the working of the colleges under its control and at least the Universities of Bombay and Madras have in the past sent such commissions.

### **Licentiate Education**

19. The majority of the medical schools are run by the State. The total is 19 of which 12 are maintained by Governments, one by the Mysore State, two by Missions and four are privately managed. The majority of these schools are in Bengal and Bombay; 9 out of 19 in Bengal and 4 in Bombay. The total number of students admitted varies from year to year but may be taken to be in the neighbourhood of 1,000. The finances of these schools are, speaking generally, most unsatisfactory, resulting in grave deficiencies in equipment, libraries, museums and laboratories. The majority of these schools cannot be considered satisfactory either from the standpoint of the clinical facilities available in the attached hospitals or from that of the number of teachers provided. The visits we paid to a number of medical schools in different



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parts of the country have made it clear that little or no improvement has been made in them in regard to the position described about six years previously by the Director General, Indian Medical Service, in his Indian Medical Review published in 1938. A statement showing details regarding the number of students admitted, equipment and staff in the medical schools in Bengal in 1944 is given below :—

*Statement showing the number of students admitted, equipment and staff in the medical schools of Bengal.*

	Total students	No. admitted yearly	Average cost	No. of microscopes	No. of teachers	No. of beds in hospitals	No. of midwifery cases yearly.
			Rs.				
1. Campbell Medical School, Calcutta.	727	168	600	13 phy. 31 Path.	14, plus 12 Demons.	717	685—1938-39 958—1939-40 1,265—1940-41
2. Dacca Medical School.	453	100	414	46 phy. 18 Path.	10 teachers 15 Demons. (All L.M.P. or L.M.F.) No teacher in Paths. 9 months.	261	105—1938-39 139—1939-40 108—1940-41
3. Lytton Medical School, Mymensingh.	220	53	203	14 Phy. 14 Path.	9 teachers (3 part time) 5 Demons.	140	110—1938-39 210—1939-40 230—1940-41
4. Ronaldshay Medical School, Burdwan.	220	50	175	16 Phy. 17 Path.	11 teachers. (4 part time) 5 Demons.	155	112—1938-39 134—1939-40 179—1940-41
5. Chittagong Medical School, Chittagong.	186	50	170	14 Phy. 11 Path.	10 teachers (7 part time) 8 Demons.	124	173—1938-39 231—1939-40 252—1940-41
6. Jackson Medical School, Jalpaiguri.	132	40	262	13 Phy. 10 Path.	10 teachers (4 part time and 3 Hony.) 6 Demons.	110	261—1939-40 337—1940-41
7. Calcutta Medical School, Calcutta.	416	100	150	..	26 teachers (All part time and 1 Honorary).	168	
8. Sammilani Medical School, Bankura.	247	68	276-9-3	12 Phy. 5 Path.	15 teachers 5 Demons.	106	81—1938-39 101—1939-40 129—1940-41
9. National Medical School, Calcutta.	380	100	343	18 Phy. 19 Path.	22 teachers 24 Demons. (All except one either part time or Honorary).	322	360—1939-40 382—1940-41

20. The absence of a central body to control medical school education has naturally led to a wide divergence of standards in the training given in the different schools and, of late, owing to the growing demand for doctors an increasing number of students has been admitted every year to the already congested, ill-equipped and understaffed schools. Without going into the defects of individual institutions it may be stated that the majority of them provide education far below reasonable standards.

21. In 1938 a conference was held in New Delhi under the auspices of the Government of India. The whole question of school medical education was reviewed and the recommendation was made that medical schools should be converted into colleges. In 1942 the Indian Medical Council passed a resolution that all medical schools should be abolished by 1947, its finding being based partly on the recommendation of the conference mentioned above and partly on the repeated appeals made to it by licentiate medical associations. Since the 1938 conference eight of the then existing schools have either been abolished or converted into colleges, but progress in this direction is slow and, in the absence of provision of adequate funds, is likely to continue to be slow.

#### **Postgraduate Education**

22. The existing facilities for postgraduate education in the different medical colleges are few. Recently there has been a great deal of activity shown by most universities in the institution of postgraduate degrees and postgraduate diplomas without, however, providing in every case the necessary facilities for adequate instruction in the subjects concerned. Madras is, in this connection, an exception. There are two university diplomas, one in Obstetrics and Gynaecology and the other in Ophthalmology, and the training, which is in both cases for a period of one academic year, is imparted in the special hospitals concerned. Government diplomas also exist in the specialities of Tuberculosis, Radiology and Clinical Laboratory Sciences with adequate provision for the training of students in these subjects. Courses for Diplomas in Public Health and in Maternity and Child Welfare are given at the All-India Institute of Hygiene and Public Health, Calcutta, as well as shorter courses in certain branches of public health work. For the Diploma in Public Health the Institute is affiliated to the Calcutta University. The Universities of Bombay and Madras also award a similar diploma, the one granted in Madras being known as the Bachelor of Sanitary Science (B.S.Sc.). Facilities for the required training are available at the Grant Medical College, Bombay, and at the Madras Medical College. In addition, the University of Calcutta grants a Doctorate of Science in Public Health (D.Sc.) and the University of Bombay a Doctorate in Hygiene (D.Hy.). Regular postgraduate courses are also provided in the School of Tropical Medicine at Calcutta.

23. In certain universities the degrees of M.D. and M.S. provide for specialisation in such subjects as Ophthalmology, Bacteriology, Anatomy and Physiology. Research degrees have also been

instituted in some universities in the non-clinical subjects of Anatomy, Physiology, Pharmacology, Biochemistry, Pathology and Bacteriology. The diplomas, that have been instituted in the different universities, include the following subjects:—

Ophthalmology.	Orthopaedics.
Psychological Medicine.	Obstetrics and Gynaecology.
Radiology.	Dermatology.
Pediatrics.	Tuberculosis.
Oto-Rhino-Laryngology.	Anaesthesia.
Venereology.	

As has already been pointed out, in many cases proper instruction courses in these subjects have not been organised at the different centres where such special degrees or diplomas have been instituted by the universities concerned. When such training facilities become available, there should be wide scope in the country for specialisation on satisfactory lines.

24. No organisation to coordinate and foster postgraduate education exists in any of the universities, except Madras where a Council of Postgraduate Medical Education has recently been formed. It is understood that a proposal for the institution of a similar organisation is under consideration in the universities of Bombay and Calcutta.

#### **The Training of Teachers**

25. No special facilities are now available in the universities for the training of teachers in the different subjects of the medical curriculum. At the same time, it is not correct to say that there are no opportunities for young men desirous of becoming teachers to work in the different departments of individual colleges and to acquire knowledge and technical skill. In some medical colleges, however, such facilities are available on a larger scale than in others. The specialities in which such training can be undertaken also vary from college to college. On the whole, however, provision for the training of teachers must be considered to be quite inadequate.

#### **Refresher Courses**

26. As far as we are aware no organised efforts have been made either by universities or by Governments to start refresher courses for general practitioners. It is understood that sporadic attempts were made in some provinces in this direction before the war, but these have not, it is understood, led to the development of such facilities on a satisfactory basis.

### **DENTAL EDUCATION**

27. Dentistry has unfortunately been one of the neglected subjects of study in practically all Indian Universities. There are at present four dental colleges: (1) the deMontmorency College of Dentistry, Lahore, (2) the Calcutta Dental College and Hospital, (3) the Nair Hospital Dental College, Bombay, and (4) the

Currimbhoy Ebrahim Dental College, Bombay. The first and the last are supported by the Governments of the Punjab and Bombay respectively, while the other two are under private management. The college at Lahore is the only one which is affiliated to a university.

28. The Calcutta Dental College and Hospital was established in 1920 and the Nair Hospital Dental College in Bombay in 1932. These two institutions were developed in the face of great difficulties and with inadequate financial support. They suffer, to some extent, from insufficiency of accommodation, of suitable equipment, staff and teaching facilities, particularly with regard to the clinical teaching material available in the hospitals concerned. The Calcutta Dental College and Hospital is affiliated to the State Medical Faculty of Bengal in accordance with the provisions of the Bengal Dental Act of 1939. The course is one of four years for new entrants and of two years for qualified medical practitioners. The Nair Dental College, Bombay, also offers a four years course, the examination being conducted by examiners appointed by the Bombay Government. The minimum educational qualification required for admission to both these Colleges is the Matriculation Examination of an Indian University. Each of these colleges takes in about 30 students and, during normal times, an average number of twenty students passes out from them every year.

29. The deMontmorency College of Dentistry, is, as has already been pointed out, affiliated to the Punjab University and the instruction given leads to a university degree in dentistry, the B.D.S. (Bachelor in Dental Surgery). This affiliation was granted in 1938. A separate Faculty of Dentistry was created in the same year. The preliminary educational qualification required for admission is the Intermediate in Science of an Indian University or a qualification recognised as equivalent to it. The course extends over a period of four years and an examination is held at the end of each year of study. The medical subjects of the curriculum are taught at the King Edward Medical College, Lahore, while the courses in dentistry subjects are given by four professors, who have direct charge of the several departments of the hospital. The paid staff of the College includes a Principal, who is also the Superintendent of the Hospital, three other full-time professors, four demonstrators and one part-time assistant dental surgeon. The number of annual admissions is about 20.

30. The average number of students trained each year at the Currimbhoy Ebrahim Dental College, Bombay, is not known, although it is understood that the number is less than that trained in the Nair Dental College. It will thus be seen that the total number of qualified dental surgeons produced in the country annually is small, probably not more than 60 or 70.

31. Facilities for postgraduate training in dentistry hardly exist in this country. The number of qualified dentists in India is not definitely known but is not likely to exceed 1,000. The number of persons with advanced training in foreign countries is strictly

limited. An essential step for the development of undergraduate and postgraduate training centres in dentistry in India is the provision of trained teachers. Facilities should therefore be provided for a selected number of dental surgeons from this country to undergo advanced training abroad.

### NURSING EDUCATION

32. *Preliminary educational qualifications and the training course for nurses.*—In some provinces there are two grades of nursing qualification—the senior certificate of nursing and a junior certificate of nursing. For the senior certificate of nursing, the Junior Cambridge or a completed Secondary School Leaving Certificate or eligibility for University courses of study is generally demanded. For the junior certificate, the VI or VII standard and, in some cases, the III standard vernacular is accepted as sufficient. Nurses are being trained in English as well as in all the principal Indian languages. The period of training is not uniform and ranges from three to four years. The curriculum differs in the provinces, but in most cases, the four years course includes also training in Gynaecological Nursing and in Obstetrics and in some provinces, it is compulsory for every nurse to have a combined sick-nursing and midwifery training. The examinations are conducted by special examination boards appointed either by the Government or by the Provincial Nursing Council concerned. Male nurses are also trained in some provinces and the trend is towards opening the profession to all, irrespective of sex.

#### Training Schools

33. The training schools for nurses are not of a uniform standard. Many of them do not come up even to the minimum standards usually required for such training. In the majority of these schools the services of the nursing student are used to supplement the work of the nursing staff of the hospital concerned and she is treated rather as an employee of the hospital than as a student who ought to be given proper training. There are only a few hospitals which place the interests of the pupil nurse above that of the hospital and give her the kind of treatment which a medical student, for instance, gets in a medical college and its affiliated hospitals. Another serious defect is that the accommodation provided for these pupils is extremely unsatisfactory. Deplorable living conditions, with gross over-crowding, is the rule rather than the exception. The fact that these hospitals are generally very much understaffed and that the pupil nurses are required to participate in the routine duties of the hospital results in their being given little or no opportunities for recreational and cultural activities.

34. The pay, status and general service conditions of the nurses require considerable improvement if the proper type of women is to be attracted to this service in adequate numbers. This subject has been discussed in the chapter dealing with existing provision for medical relief and preventive health services in the provinces.

### Postgraduate Training for Nurses

35. The trained nurse in India has very few facilities for postgraduate training. Recently the Bombay Nursing Council started an advanced course in midwifery and pediatrics nursing, which provides training facilities for nurses specially interested in either of these subjects. In Madras a short six months' course for postgraduate study for nurses has recently been instituted. The Government of India opened in 1943 in Delhi a School of Nursing Administration, which provides a course for nurses to qualify as certificated sister tutors, and a course of study in hospital nursing administration. This latter course has had to be devoted, so far, almost entirely to the requirements of the Army and consequently the curriculum was modified accordingly.

### THE TRAINING OF CERTAIN TYPES OF PUBLIC HEALTH PERSONNEL

36. Existing facilities for public health training for undergraduate medical students and postgraduate training for doctors have already been discussed in the section dealing with medical education. We shall here confine ourselves to the training of health visitors, midwives, *dais*, sanitary inspectors, vaccinators and public health engineers.

#### The Training of Health Visitors

37. There are training schools for health visitors at Lahore, Delhi, Lucknow, Calcutta, Madras, Poona, Bombay and Nagpur. The preliminary educational qualifications required for admission to these schools, the periods of training, the syllabuses followed and the languages in which instruction is given, vary considerably. The general education required is as low as the third class of the Anglo-vernacular school in Poona and as high as the Matriculation or its equivalent in Madras and Delhi. The authorities of certain schools insist that the preliminary educational qualifications should include a midwifery diploma and preference is given to candidates who possess, in addition, the certificate for general nursing also. Other training schools do not require even the midwifery certificate for admission. The period of training extends from nine to eighteen months. The medium of instruction is, in some schools, English and in others the local Indian language. The final examination is held by the Provincial Nursing Council or by authorities appointed by the Provincial Government.

38. The course of training includes work in a maternity and child welfare centre maintained either by the local health department or by a voluntary agency. Field training in rural and urban health centres is also included in the course.

39. The best type of health visitor available in the country is normally a qualified midwife with some elementary training in general hygiene and preventive health work. Her main duties are to supervise the domiciliary work of midwives and of trained *dais*, where the latter are employed, and to participate in preventive

work associated with the hygiene of pregnancy and of the postnatal period. On the other hand the tendency in the countries, where health administration is more advanced than in India, is to create and employ a type of woman worker known as the public health nurse, who, under the guidance of the doctor, is able to take part in the extension of preventive health work in all fields of activity to the homes of the people. The training of such a worker includes the course for sick-nursing and for midwifery, with special emphasis laid, throughout the period of instruction, on the preventive and community aspects of health administration. In developing a health programme on modern lines India will also require the services of this general type of preventive worker and the question of introducing suitable modifications into the existing training courses for health visitors will require consideration.

### **The Training of Midwives**

40. The period of training for midwives varies in the different provinces. In the case of fully certificated nurses the midwifery training included in the course extends over a period which varies from six months to one year. In the case of those who are trained only as midwives the course varies from one to two years. The inclusion of domiciliary practice in the training is by no means general. In a certain number of the training institutions in the North-West Frontier Province, Madras, the Central Provinces and Assam provision for domiciliary training exists. There is no such provision in the training centres in the Punjab, Delhi, Bombay and Sind. The examination for midwives is conducted by a Board appointed by the Government or by the Provincial Nurses and Midwives Council concerned.

41. As in the case of pupil nurses, the training centres for midwives make use of pupils to make up the shortage in the personnel of the hospitals concerned. A number of training centres are defective in that the facilities for giving antenatal instruction are insufficient as well as the amount of clinical material available to enable the pupils to obtain a thorough appreciation of the normal and abnormal conditions pertaining to labour. Taking into consideration the number of beds, the total number of doctors and other requirements for the satisfactory training of pupil-midwives, the number of those admitted into certain institutions is far in excess of that which can be properly trained. Our remarks regarding accommodation and other amenities in respect of training institutions for pupil nurses apply equally to the training institutions for midwives. In fact, in many cases the conditions are worse.

42. Although there are approximately 11,000 certified midwives and 700 assistant midwives on the registers maintained by the Provincial Nursing and Midwives Councils, the actual number of practising midwives is much less, probably about 5,000 in the whole country. Some of the causes for this discrepancy are that many nurses, who are qualified as midwives and yet do not practice this profession, are included in the lists, that some are registered

in more than one province and that, as the registers have not been kept up to date, the names of those who have died, have given up practice or left the country, have not been deleted. For the provision of adequate midwifery aid to all women undergoing childbirth in British India about 100,000 midwives will be required on the basis of one midwife for 100 births. If the estimated number of 5,000 practising midwives in the country is even approximately correct, it will be seen that the existing training facilities for this class of health worker will have to be developed on an enormous scale, in order to meet the requirements of the country.

### **The Training of *Dais***

43. The training of indigenous *dais*, i.e., of persons whose hereditary profession is the practice of midwifery, has been attempted in certain provinces. It is not easy to wean the *dai* from her normal objectionable methods and many, who have been associated with the training of this class of person in modern midwifery, have naturally expressed doubts of the possibility of converting the *dai* into a useful worker. We would, however, point out that the past efforts in this direction have largely failed because of the lack of adequate provision for the supervision of the work of trained *dais* as well as for periodical refresher courses. If such provision is made we believe that it should be possible to make the *dai* a fairly satisfactory accoucheuse. The difference between the existing number of midwives and that required by the country to provide adequate service is enormous. Any conceivable extension of training facilities cannot, we feel, help to make up this difference within a reasonable period of time. In the meantime it seems to us essential that, during this interim period, every effort should be made to make available a service which, although it may not be of the high standard that modern health-administration demands, will yet be an improvement on what the vast majority of the women of India are now able to obtain. In attempting to do so, we feel that the possibility of utilising the services of the hereditary class, which has been rendering midwifery aid to the people for centuries, with such safeguards as may be necessary, cannot be ignored.

### **The Training of Public Health or Sanitary Inspectors**

44. In Delhi Province, the Central Provinces, the North-West Frontier Province and Assam no facilities exist for the training of sanitary inspectors. In Bihar and Bengal the course has been held in abeyance. In Orissa and the United Provinces the course is said to be held only as and when the need for it is felt. The only provinces where the course is held regularly are Madras, Bombay, the Punjab and Sind. These four together provide training facilities for about 300 sanitary inspectors each year, while the number of those who qualify is approximately 200. If the schools in Bihar, Orissa, and the United Provinces again begin to train sanitary inspectors, about 100-150 more candidates can be admitted for training and about 70-100 more qualified men may become available annually.



45. The period of training varies from six weeks in Bihar to one year in Madras and Orissa. The basic qualification necessary for a candidate before he is admitted for training is not uniform throughout the country. While in Madras the secondary school leaving certificate or the matriculation is required (it is understood that often candidates who have passed the Intermediate Examination of the University apply for the course) the initial qualification required in certain other provinces is much lower. The syllabus followed is also not uniform. The existing syllabuses lay greater emphasis on the theoretical rather than on the practical aspect of training. Further, greater consideration is given to urban than to rural health problems. India requires in large numbers a type of sanitary inspector who can participate effectively in the practical application of modern hygiene to rural health conditions, and adequate consideration will have to be given to this requirement in evolving a satisfactory course of training for this class of health worker.

#### **The Training of Vaccinators**

46. The basic educational qualification required for the vaccinator's training varies in the different provinces but it is usually the middle English or the middle vernacular standard. The duration of the training ranges from three months to ten months. In most provinces this training includes instruction in elementary hygiene so as to fit the vaccinator for assisting in public health work. Practical training in the field is given by a senior vaccinator under the supervision of a medical officer of health or by the latter himself. In most of the provinces additional training is also given at the local vaccine institute, where vaccine lymph is manufactured.

47. It is understood that, a short while ago, a special investigation was carried out by an officer deputed by the Public Health Commissioner with the Government of India into the various aspects of vaccination against smallpox, including the preparation and distribution of vaccine lymph, the conduct of vaccination and the training of vaccinators. It is hoped that the standards of training for vaccinators in the different provinces will be raised and made uniform, as the result of the action taken on the recommendations of this officer.

#### **The Training of Public Health Engineers**

48. Existing engineering colleges in India have not yet differentiated sanitary or public health engineering as a special subject. Some instruction in this subject is given, mainly in hydraulics, to civil engineering students but this part of the course occupies only a minor place in the curriculum. A Diploma in Sanitary Engineering and Plumbing is awarded by the Victoria Jubilee Technical Institute, Bombay.

"The course is open to those who have passed the Intermediate in Science Examination of an Indian University or a higher examination, or who pass the entrance examination conducted by the Institute, which is equivalent to the Bombay

**Matriculation.** The course extends over a period of four years including a six months practical course. The Diploma is awarded on the results of an examination conducted by the Board of the Institute."

As far as we are aware this is the only institution in which a systematic course in the subject is available at present.

49. Civil engineers in India generally lack a biological background and are not adequately equipped to apply the principles of public health to the improvement of environmental conditions. There are separate Public Health Engineering Departments in the Punjab, the United Provinces, Bengal and Bombay, each with a small staff, and there is a Sanitary Engineering Branch of the Public Works Department in Madras. With a few exceptions, the engineers in these Departments have had no special training in Public Health Engineering. We should explain that India is by no means unique in this. The idea of public health engineering is relatively modern and has mainly been developed in America. We have indicated, in more than one place in this report, the unfortunate consequences of carrying out public works on a large scale without due regard to the public health aspects of such undertakings. The institution of special training facilities in Public Health Engineering for qualified engineers as well as the inclusion of more detailed instruction in this subject in the curricula for civil engineering students in the different colleges must, in our view, receive serious consideration.

## PHARMACEUTICAL EDUCATION

50. Existing facilities for pharmaceutical education in India are quite insufficient. Three types of training are available: (1) the compounder or dresser qualification, (2) the chemists and druggists qualification and (3) a college education leading up to a degree in pharmacy.

### The Compounder or Dresser

51. The period of training for a compounder's qualification varies from one to two years and the preliminary qualifications demanded in the different provinces are not uniform. In some, candidates who have completed the middle school examination are admitted, while in others the completion of a high school education is required. The candidates are usually trained first in district headquarters hospitals and are then given an intensive short course in some central hospital. In Bengal, since 1928 the training period for compounders has been increased to two years, of which the first year has to be spent in some specified institution, where the candidate receives instruction in materia medica, the laws regulating the sale of poisons and practical pharmacy. This is followed by an examination after which the second year is spent in apprenticeship in a chemist's or druggist's establishment or at a hospital. In Madras candidates are required to have the basic qualification of a Secondary School Leaving Certificate. They are given practical training for nine months in certain selected district headquarters

hospitals and later an intensive course lasting three months at the Madras General Hospital. They are also given training in first aid.

52. *Chemists and druggists.*—The preliminary educational qualification for entry to the course is a School Leaving Certificate and the period of training lasts for two and a half years. This includes apprenticeship with a recognised firm of pharmaceutical chemists during the last year of study. The subjects included in the curriculum are chemistry, both organic and inorganic, botany, pharmaceutical chemistry, materia medica and pharmacy.

53. *Collegiate education.*—This is designed to turn out a class comparable to the graduate pharmacists or pharmaceutical chemists found in Europe and America. The Benares Hindu University was the first to inaugurate a course of this kind in 1934 and, since that time, other universities have also provided similar training facilities. The Andhra University instituted the study of 'Pharmaceutics' as a special subject in the curriculum for the B.Sc. (Honours) and M.Sc. Degree in Chemical Technology. The Calcutta University has a course in Pharmaceutical Chemistry for M.Sc. students. The Bombay University has opened a new course in Pharmaceuticals in their Technological Faculty. The Madras University has inaugurated a two years course, B.Sc. (Phar.), for which students who have passed the Intermediate examination in Science are eligible. Thus graduate instruction in pharmacy is of two types, one which deals mainly with the technical side of it and the other which stresses the pharmaceutical side.

### THE TRAINING OF TECHNICIANS

54. We include here that class of persons who work as laboratory attendants and as radiological assistants. There are very few institutions in the country which train technicians of the above types, who are needed in large numbers as auxiliaries to the medical services. The usual method of training laboratory technicians is for an institution to take on, as an attendant, a person who need have no preliminary educational qualification. He is expected to get his training by taking part in the day to day working of the laboratory.

55. Within recent years facilities for the training of laboratory technicians have been organised in a few Mission institutions, particularly at Vellore, Madanapalli and Allahabad, under the auspices of the Christian Medical Association of India, Burma and Ceylon. A register of trained laboratory technicians has been opened. The rules for such training include a minimum educational qualification corresponding to the matriculation or its equivalent and a course of study lasting not less than nine months. The candidates are given a fairly complete practical training for the types of work connected with pathological, bacteriological and biochemical laboratories. The rules require that the training should be given in a hospital with a well-equipped laboratory and

with a minimum of 2,000 in-patients per year and a daily average of 100 in-patients. The number of students allotted to each member of the teaching and demonstrating staff is limited to two.

56. In Madras a training course for radiographers is given at the Government Radiological Institute. The course qualifies for the diploma of Certified Radiological Assistant (C. R. A., Madras), which is open to those who have passed the Secondary School Leaving Certificate Examination with science subjects or the Matriculation or its equivalent. The period of training lasts one year and consists of three parts. Part I comprises instruction in elementary anatomy, physiology and pathology. This is followed by Part II, which includes radiography, radium and X-ray treatment and electrolgy. Part III of the course lasts three months and is devoted to practical training. An examination is held at the end of each of the three parts.

57. No training facilities exist at present in this country for a number of types of technicians, including physical therapists, dietitians, occupational therapists and dental hygienists. There is also no provision for the training of technicians for public health work.

### THE TRAINING OF HOSPITAL SOCIAL WORKERS

58. The Sir Dorabji Tata School of Social Service in Bombay is, we believe, the only institution in India which provides facilities for the training of social workers. This school has, on the whole, followed the American model and in a two-year course it provides instruction for social workers in the fields of family and child welfare, adult delinquency and industrial and labour problems. There is also a course, which includes medical and psychiatric social work and instruction on social case work and family case work. If the authorities who run this School are able to add instruction in certain special diseases such as tuberculosis, venereal diseases, etc., courses will become available here for the training of social workers in a wide range of health activity.

59. There are no facilities, anywhere in the country, for the training of hospital social workers. We feel that adequate provision for this constitutes an urgent necessity. We have little doubt that the general efficiency of all the larger hospitals in India will be greatly increased by appointing trained hospital social workers on their staff, as has been the experience recently in Great Britain and in America. They are also required if the training of the medical student in preventive medicine and public health is to be organised on sound lines.

## CHAPTER XIV

### MEDICAL RESEARCH

#### BRIEF HISTORY OF THE DEVELOPMENT OF MEDICAL RESEARCH IN INDIA

1. The present organization of medical research in India is the result of progressive development over the last 40 years. Prior to the beginning of the present century no regular organization existed and such research work as was done was carried out by medical officers on their own initiative and with their own resources, or, occasionally, by individual officers deputed by Government to investigate special problems. The studies of some of these earlier workers are classical and amongst them may be cited the work of Lewis on trypanosomes; of Carter on the spirillum of relapsing fever, leprosy, and mycetoma infections; of Macnamara and Cunningham on cholera; and of Fayer on snakes and snake venoms. At a later date, Ross made his epoch-making discovery while employed in routine military duty.

2. The first bacteriological laboratory in India was founded at Agra in 1892 when Hankin was appointed as Chemical Examiner and Bacteriologist, and, with his training under Pasteur and Koch, he was able to stimulate interest in the subject in India. It was later proposed that a laboratory for the whole of India should be established under Hankin's direction but the scheme did not materialize. About this time the discovery of the aetiological agents of plague and cholera, the work of Manson, Ross and others on the insect transmission of disease and the working out of the life-cycles of many human parasites were opening up a promising field for medical research. Such work, with its possibilities of great and original discoveries, naturally attracted enthusiastic medical workers but few facilities for research existed and there was little opportunity for training. The first appearance of plague in Bombay in 1896 and its subsequent spread over vast areas in India, at a time when little was known of its epidemiology or of the preventive measures which should be applied, emphasized the necessity for an organization for research on such subjects. Immediate work had to be undertaken on plague and for this purpose Haffkine, who was then studying prophylactic inoculation against cholera in Bengal, was deputed to Bombay.

3. In 1899, the Sanitary Commissioner with the Government of India (Surgeon-General Harvey) submitted definite proposals for the organization of research laboratories. His scheme provided for a Central Research Laboratory and for a local laboratory in each Province and Military Command, but there was considerable delay in implementing this scheme although it was approved by the Provincial Governments, and, generally, by the Secretary of State.

4. In the meantime Haffkine's successful manufacture of plague vaccine necessitated the provision of accommodation on a large scale and for this purpose the Old Government House, Parel, Bombay, was taken over as a laboratory.

Although a number of workers had suggested the possibility of the rat flea as a vector of plague, conclusive proof had not been obtained. This problem was worked out in detail by a Commission appointed to work under an Advisory Committee the members of which were nominated by the Secretary of State for India, the Royal Society and the Lister Institute of Preventive Medicine, London.

5. A project had been under consideration for a number of years to establish a Pasteur Institute in India, and Kasauli was selected for the purpose. The Institute was opened in 1900. When the scheme for the establishment of a central institute for medical research was finally approved, Semple, who was then Director of the Pasteur Institute, was selected as Director, and in view of his experience, his view that Kasauli should be selected for the purpose prevailed and the Central Research Institute was opened there in 1906.

6. Prior to this the King Institute of Preventive Medicine had been opened at Guindy, Madras, in 1903-04 with functions largely of a public health nature, including the manufacture of calf-lymph, but also with provision for general bacteriological work and research on bacteriological and other problems related to tropical medicine.

7. Thus, at the time the Central Research Institute was opened, two of the Provinces had large Institutes available for both routine laboratory work and research, viz., the Bombay Bacteriological Laboratory, Bombay (later called the Haffkine Institute) and the King Institute, Madras. In addition, the Pasteur Institute of India, Kasauli, also served as a Provincial Laboratory for the Punjab and as a research centre.

8. In order to staff these various institutes a permanent cadre of specially selected and trained medical officers was established. This cadre was originally known as the Bacteriological Department and is still in existence as the Medical Research Department of the Government of India.

9. The following Institutes and laboratories were subsequently founded and opened in the years stated:—

<i>Madras.</i> —The Pasteur Institute of Southern India, Coonoor . . . . .	1907
<i>Burma.</i> —The Pasteur Institute of Burma, Rangoon . . . . .	1915
<i>Assam.</i> —The Pasteur & Medical Research Institute, Shillong . . . . .	1917
<i>Bengal.</i> —The School of Tropical Medicine, Calcutta . . . . .	1922
<i>All-India.</i> —The All-India Institute of Hygiene and Public Health, Calcutta . . . . .	1932
<i>All-India.</i> —The Malaria Institute of India, Delhi . . . . .	1939

10. The two institutes in Bengal, although primarily designed for teaching purposes, have carried out research on a large scale and many special research inquiries have been located in them.

11. The demand for routine laboratory services and for manufacture of vaccines and sera developed rapidly and it soon became apparent that the officers put in charge of laboratories were becoming increasingly involved in administrative work and routine manufacture at the expense of their true research work; they had become to a large extent immobile and were no longer available for field investigations, to which it had been intended they should devote a large part of their time and energies.

12. In 1914, to deal with this position, the Government of India created 15 additional posts to bring the cadre of the Bacteriological Department up to 30. It was intended that the additional officers should be available for whole-time research either in the field or at existing laboratories. With the outbreak of war in 1914 the scheme could not be brought into effect. Instead of extra officers being recruited and research activities extended, many officers on the small existing cadre were reverted to military duty and research work was greatly reduced.

13. A step forward in the development of medical research in India was the creation of the Indian Research Fund Association in 1911. The Governing Body of this Association appoints a Scientific Advisory Board to advise on technical matters and allocation of funds. The Association approves an annual programme of research, sanctions grants-in-aid for research, and, in certain cases, may constitute special inquiries. An annual conference on medical research is normally held at which work of the past year is reviewed, and proposals for the coming year put forward.

14. In the past, applications for grants-in-aid for specific inquiries have been made chiefly by workers in the Central and Provincial Government Laboratories, and remarkably few have been received from the Medical Colleges and Schools of India.

15. In addition to temporary inquiries, the Association has set up and maintained certain semi-permanent organizations.

(1) *The Nutrition Research Laboratories* developed out of the Beri-Beri Inquiry and Deficiency Diseases Inquiry under McCarrison at Coonoor. A semi-permanent unit with a staff of chemists, biochemists and medical assistants was constituted at Coonoor in 1925.

(2) *The Malaria Survey of India* was constituted in 1926, and took over the functions of the Central Malaria Bureau of the Central Research Institute, Kasauli. Most of the activities formerly carried out at Kasauli are now performed in the Laboratory at Delhi. In 1940, the Survey became a charge on the Government of India and only the purely research costs were borne by the Fund. At the same time, the name of the unit was changed to the "*Malaria Institute of India*".

16. In 1935, a scheme was brought into operation for forming a junior cadre of medical research workers to give younger workers of a suitable type an opportunity of taking up research. Six appointments to this cadre were made by a Selection Board, but, beyond that, the scheme has not developed. The cadre has proved

useful, and some appointments have been made from it to the Medical Research Department.

17. In 1940, a further scheme for training recruits was adopted. This consisted in the offer of Fellowships to young graduates to enable them to obtain experience in research, but not necessarily with the promise of permanent whole-time research work or of employment under the Association. A few Fellowships have been awarded and the scheme is still under trial.

18. The Indian Research Fund Association publishes the *Indian Journal of Medical Research*, *Indian Medical Research Memoirs* and *Journal of the Malaria Institute of India*, and maintains a library at Kasauli.

19. With the outbreak of war in 1939, many of the younger workers in the Medical Research Department were recalled for military service, or joined the Army Medical Services. The result was that research activities in Central and Provincial Government laboratories and in certain inquiries under the Indian Research Fund Association were considerably curtailed. Our investigations were, therefore, undertaken at a time when medical research activities were below pre-war standard.

## SURVEY OF MEDICAL RESEARCH ACTIVITIES IN INDIA TO-DAY

### I. ORGANIZATION OF MEDICAL RESEARCH

20. Organized medical research at the present time depends mainly on two organizations:—

- (1) The Central and Provincial Government laboratories and the Medical Research Department, and
- (2) The Indian Research Fund Association.

#### 1. *The Central and Provincial Government Laboratories and Medical Research Department*

21. When the Central and Provincial Government laboratories were established it was found necessary to maintain a permanent cadre of specially selected and trained officers to staff them. At the present time there are 30 sanctioned appointments in the Medical Research Department (originally the Bacteriological Department) maintained by the Government of India. Half of these appointments are reserved for I.M.S. officers and the remainder are open to I.M.S. and non-I.M.S. medical officers. The intention has been that the Directors and Assistant Directors of the various Government laboratories should be drawn from this permanent cadre, and, until comparatively recent years, this has been done. More recently, however, the extended activities of the Provincial laboratories have necessitated the employment of workers for special duties and these have been appointed, as required, without drawing upon the Medical Research Department. Officers of the latter Department have been placed on foreign service, from time to time, with other organizations such as the Indian Research



Fund Association and the Pasteur Institute Associations. Since the outbreak of war some of the regular officers of the Medical Research Department have been recalled to military duty and at the present time only twelve officers of this Department are employed in Central, Provincial, or other civil institutions in India, of whom six are I.M.S. and six non-I.M.S.

## *2. The Indian Research Fund Association*

22. The Indian Research Fund Association is a registered association, recognized by, and in close touch with, the Government of India, from whom its funds have been mainly derived. The chief objects of this Association are:—

- (a) To initiate, aid, develop and co-ordinate medical scientific research in India, to promote special inquiries and to assist institutions for the study of diseases, their prevention, causation and remedy.
- (b) To publish papers or periodicals in furtherance of the objects of the Association and to propagate knowledge regarding the causation, mode of spread and prevention of diseases, especially those of a communicable nature.
- (c) To issue appeals and applications for funds, and to finance inquiries and researches.

23. Other objects of the Association include liaison with other scientific bodies with similar aims; to accept and administer endowments, funds and donations; to grant scholarships to selected individuals for advanced study, etc.

24. The entire control and management of the affairs of the Association are vested in a Governing Body, the composition of which is as follows:—

1. President—The Hon'ble Member of the Governor-General's Council, for the time being, in-charge of the Portfolio of Health.
2. Vice-President—The Secretary, for the time being, of the Department of Health, Government of India.
3. The Director-General, Indian Medical Service.
4. The Public Health Commissioner with the Government of India (Secretary of the Association).
5. The Director, All-India Institute of Hygiene and Public Health, Calcutta.
6. The Director, Central Research Institute, Kasauli.
7. The Director, School of Tropical Medicine, Calcutta.
8. An eminent non-medical scientist elected by the Council of the Indian Science Congress.
9. One representative elected by the Council of State.
- 10 & 11. Two representatives elected by the Legislative Assembly.

12, 13 & 14. Three representatives of medical faculties of universities who have had training and experience in medical research or public health.

15. The Maharaja of Parlakimedi (life member).

25. Members of the Association may be *ex-officio* holders for the time being of certain offices, or individual donors or subscribers, or may be elected or nominated as members as prescribed in the Rules and Regulations of the Association. The Governing Body appoints at each annual meeting a Scientific Advisory Board of which the Director-General, Indian Medical Service is Chairman, and the Secretary of the Association is Secretary. Members of this Board hold office for one year, but are eligible for re-election. They need not necessarily be members of the Association. There is no restriction as to the numbers appointed to the Scientific Advisory Board, and the Board itself has power to co-opt additional members for any particular meeting or purpose. The Board also has power to appoint Advisory Committees for special subjects and to nominate the Chairman and Secretary of such Advisory Committees. There is no restriction on the number and size of the Advisory Committees appointed, and they have the power, subject to the approval of the Chairman of the Board, to co-opt additional members. It is thus within the competence of the Indian Research Fund Association to obtain the widest possible scientific representation in the actual conduct of the affairs of the Association.

26. In normal times a Research Workers' Conference is held annually which provides a democratic scientific forum in which workers, including the most junior, have the opportunity freely to express their opinions both on scientific matters and on the organization and control of researches sponsored by the Association.

The presence of Public Health Officers and representatives of other interests at these conferences makes it possible to bring into focus the interplay of research and practical health activities. The Indian Research Fund Association, therefore, serves a function, not provided for by other agencies, in bringing into the field of medical research, workers in laboratories other than the Central and Provincial laboratories maintained by Government.

### 3. Other Organizations

27. In addition to the two chief provisions for the organization of research referred to above, there are others of comparatively minor importance. These include the provision for research made by the Endowment Funds of the School of Tropical Medicine, Calcutta, of the Pasteur Institute Associations in India, and of the Indian Council of the British Empire Leprosy Relief Association.

Of the above, the Indian Research Fund Association is the most important organization for medical research in India at the present time.

## II. THE CENTRAL RESEARCH INSTITUTE AND OTHER CENTRAL GOVERNMENT LABORATORIES

### 1. *The Central Research Institute, Kasauli*

28. The Central Research Institute, Kasauli, was opened in 1906 as a Central Government Bacteriological Laboratory. The original intention was that the staff of the Institute should devote the greater part of their time and energies to the conduct of medical research both in the laboratory and in the field. With the passage of time, however, the ever-increasing demand for vaccines and sera manufactured at the Institute, and other important routine duties, have progressively reduced the time available for research until the unprecedented demand for vaccines and sera for the Defence Department, and the reduction in staff effected since the war, have reduced research activities to the lowest level in its history.

29. The Institute is financed by the Government of India and is controlled by the Director-General, Indian Medical Service, for the Department of Health of the Government of India. In normal times, the revenue from the sale of vaccines and sera manufactured at the Institute covers all running expenses and, at the present time, considerably exceeds this amount.

30. The Institute is provided with two cool rooms. Animal stocks are adequate for present needs. Accommodation for office and stores is already congested. There is no separate Anaerobic Block, and work of this kind cannot, at present, be permitted owing to the undesirability of working with anaerobic organisms in buildings used for the preparation of vaccines and sera for human use.

The routine work of the Institute consists of:—

- (1) The large scale manufacture of T. A. B. Vaccine (chiefly for the Defence Deptt.); Cholera Vaccine (for the Defence Department, Punjab, N.-W. F. P., Kashmir, and other States in Northern India; *plus* emergency supplies for Assam, Burma and Bengal); Anti-rabic Vaccine, both for human and animal use (for the Defence Deptt., Punjab, U. P. and certain States in Northern India); Anti-venom Serum (for the whole of India, including the Defence Deptt.); Sterilized Surgical Ligature (as an emergency supply to the Defence Deptt. in 1942-43).
- (2) Laboratory diagnostic work, on a limited scale, for hospitals and practitioners.
- (3) The testing of disinfectants for Government of India contracts.
- (4) The Director is the Adviser to the Government of India (through the D.G., I.M.S. and the P.H.C.) and is also a member of the Army Pathology Advisory Board and of the Drugs Technical Advisory Board. In addition, advice is sought by many others including Administrative Medical Officers of Provinces and States, private

practitioners and research workers all over India. Advisory work is very heavy and is becoming increasingly more so. It covers a very wide field and often necessitates extensive library work, and even *ad hoc* research.

- (5) For many years the Institute has accepted responsibility for the storage and distribution of all imported and indigenous sera for the Defence Department under instructions issued by the Director of Medical Services in India, to whom the Director is Adviser on all matters connected therewith.
- (6) The Institute is the receiving and distributing centre, for India, for international standard anti-toxins received from the National Institute for Medical Research, London.
- (7) The Institute is a recognized centre for yellow fever inoculation. The potency of the stocks of yellow fever vaccines maintained is estimated quarterly.
- (8) A diagnostic unit is maintained, which can proceed at short notice to investigate and verify the suspected occurrences of yellow fever in any part of India.
- (9) Since the war, the Institute has been made responsible for the inspection, on behalf of Government, of commercial concerns in India with a view to their recognition by the Government as approved suppliers of various products, including vaccines, sera, sterilized surgical ligature, and sterile solutions for parenteral injection.
- (10) Control sterility tests are carried out on a large scale on samples of consignments ordered by Government prior to their acceptance.
- (11) Samples of vaccines are tested, as required, on behalf of public health authorities for sterility, specificity and protective value.
- (12) The preparation and issue of high-titre sera, standard agglutination suspensions, type sera for blood grouping, etc.

31. At one time, organized bacteriological courses were held at the Institute, but these have been in abeyance for many years. Requests are, however, often received for the training of medical officers or technicians in various branches of work at the Institute. Individuals trained in this way have come from Provinces and States in India, from commercial firms in India and from overseas.

32. The Institute has, for many years, provided accommodation for the library and central stores of the Indian Research Fund Association, and for the office of the *Indian Journal of Medical Research* of which the Director of the Institute is the Editor. One specialized publication assistant assists in editing the *Indian Journal of Medical Research*.

The Institute is organized in six sections which are at present :--

- |                            |                                    |
|----------------------------|------------------------------------|
| (1) Administrative Section | (4) Rabies Section                 |
| (2) General Section        | (5) Serum Concentration Section    |
| (3) Vaccines Section       | (6) Serum Standardization Section. |

The sanctioned staff of the Institute consists of the Director, 3 Assistant Directors, 5 Military Assistant Surgeons and suitable subordinate establishment. The Staff total, in all, about 170.

33. In addition to the above staff, there is at present one super-numerary officer financed by the Indian Research Fund Association who is in-charge of the Serum Standardization Section. One Assistant Directorship is at present unfilled owing to the war. All of the above officers are whole-time employees and none of them is engaged in private practice.

The equipment available is not in all respects satisfactory for the routine work at present in hand. Some of it is old fashioned and badly worn. Equipment for research work is limited.

The Institute maintains an excellent library for the type of work undertaken and these facilities are enhanced by the availability of the library of the Indian Research Fund Association. A trained librarian is maintained.

The Institute has a fine record of research achievement carried out over a period of nearly 40 years and has gained for itself a name of international renown. It is natural that in a small isolated place, such as Kasauli, much of the research carried out has been of a basic nature. Nevertheless, much of this fundamental research has proved to be of importance in practical fields of work. Important field investigations have also been undertaken as, for example, the classical study on the epidemiology of malaria by Christophers in the Punjab and at Singbhum; the investigations on typhus and relapsing fever by Cragg, and later the field inquiries on kala-azar, cholera, etc., financed by the Indian Research Fund Association.

Kasauli has the distinct advantage of a healthy and temperate climate, in which it is possible to work at high pressure throughout the entire year and it is more suitable for many types of work than most plains stations. It is especially suited to the preparation of biological products under ideal conditions and to the breeding and maintenance of healthy animal stocks.

## *2. The Malaria Institute of India.*

34. 'The Malaria Institute of India' or as it was formerly named 'The Malaria Survey of India', developed from the Central Malaria Bureau and the Entomology Section of the Central Research Institute, Kasauli. The pressing need for a separate organization to undertake teaching and research on Malariology had been keenly felt in the years immediately after the first Great War. This need was met by the inauguration of the Malaria

Survey of India in 1926 as a semi-permanent inquiry under the Indian Research Fund Association. As in the case of many of the Government Laboratories engaged in other lines of work, the Malaria Survey of India, originally designed as a teaching and research organization, soon began to have forced upon it more and more work of a routine or public health nature. In 1940, the Government of India took over that part of the Malaria Survey of India engaged in duties of this kind. The research activities of the organization continued to be financed by the Indian Research Fund Association. At the present time, therefore, the Malaria Institute of India is made up of a Public Health Section and a Research Section financed by the Government of India and by the Indian Research Fund Association respectively. In practice this division of activities is largely artificial, research going on hand in hand with the public health activities of which it forms an essential part. The functions of the Institute are many and varied but they may be summarized as follows:—

- (1) To be fully informed upon all malaria problems, and to advise Government on all issues relative to malaria in India.
- (2) To initiate inquiries and investigations on malaria; to carry out such inquiries as Government may for any reason require; to assist provincial organizations in the carrying out of such inquiries as may be undertaken by them, providing such assistance as desired and even, when thought necessary, to lend officers temporarily from the staff to work under local governments.
- (3) To undertake systematic research into all the basic facts underlying malaria transmission, prevalence and prevention such as the study of mosquitoes, systematic and bionomical; types of malaria parasites; transmission power of different species of Anopheles; mechanism of infection including the study of endemic and epidemic phenomena, etc.; gradually to complete and organize knowledge on these subjects and to arrange for the making of such knowledge available for practical application, or such other uses as may be desirable.
- (4) To carry out epidemiological investigations, mapping of endemicity, study of hyper-endemic and healthy areas, study of malaria statistics on modern lines, and generally to elucidate the underlying principles of malaria prevalence in India.
- (5) To advise upon and assist in the carrying out of anti-malaria measures; to study these scientifically and to judge and elucidate their results.
- (6) To undertake clinical work on malaria, including treatment; to study serum reactions and allied aids to diagnosis; to study relapse problems, effects of new drugs, etc.

- (7) To assist affiliated researches (e.g. kala-azar, filariasis, sandfly fever, dengue, stegomyia work) by identification of material; provision of trained staff and subordinate personnel.
- (8) To teach and train officers and others in practical malaria work.
- (9) To publish scientific results, useful guides, bulletins, etc.
- (10) To keep alive interest in malaria study and prevention and to see that such interest wherever present is nursed and assisted.

35. The existing staff has been reduced owing to the war and is at present inadequate to cope with the functions summarized above. Two appointments for research workers are at present in abeyance and research activities are strictly limited to certain subjects directly connected with the control of malaria in war.

36. In 1942, advantage was taken of the generous offer of the Rockefeller Foundation to donate the equipment of Dr. Paul Russell's Research Unit at Coonoor to form a much needed branch in Southern India. Owing to shortage of staff, it has not been possible to place an officer permanently in charge to control and supervise the activities of the South India Branch. One of the functions of this Branch in South India will be to advise not only the Madras Presidency and the neighbouring Indian States, but also the numerous Tea and Coffee Plantations and other industrial concerns who frequently apply for advice on malaria-control measures to the Director of the Pasteur Institute, Coonoor.

37. Although the Malaria Institute has been in existence for less than 20 years, it has carried out a large volume of research work of the highest quality and has established for itself a reputation for malaria research which is probably unequalled by any other single organization in the world.

The original headquarters of the Malaria Institute were located in the buildings of the Central Research Institute, Kasauli. In addition, a large Experimental Station was maintained in a hyper-endemic area at Karnal for the purpose of conducting field researches, translating the results of research work into practice, and conducting advanced courses of instruction on malaria. In 1936, the Malaria Institute was required to assume responsibility for the direction and supervision of a large scale anti-malaria project in Delhi. This necessitated the residence at Delhi of a considerable proportion of the staff of the Institute, and in 1940 the Government of India placed a suitable building in Delhi at the disposal of the Institute. Subsequently, the Experimental Station at Karnal was given up and the work previously carried out both at this Station and at headquarters in Kasauli was transferred to Delhi. The Institute still retains its library, stores and two laboratories at Kasauli.

38. The courses of instructions on malariology now given to Medical Officers of the Army, Central and Provincial Government

services, railways, industrial concerns, etc., have been of great value in spreading knowledge of malaria throughout India and in stimulating malaria investigation and control in many parts of the country. In addition to these courses, special classes of instruction have been held regularly for the training of engineers in the principles and practice of malaria prevention. Since the outbreak of the war, special courses have been held for medical officers of the Armies, Navies and Air Forces of British, American and other allied countries. The Director of the Institute is Consultant Malariologist to the Army in India.

### 3. *The Biochemical Standardization Laboratory*

39. This Laboratory was organized in 1936 in order to train personnel in the technical methods of testing pharmaceutical and other products against the time when legislation would be introduced to control their manufacture by commercial firms in India. The intention was that when the Drugs Act became law, the Biochemical Standardization Laboratory would be re-constituted as the Central Drugs Control Laboratory. Although the Drugs Act was passed in 1940 and the Drugs Rules, 1945, have recently been promulgated by the Government of India, this legislation has not yet been brought into operation. The Laboratory is organized in sections for work on Pharmacology and Bio-assay, Pharmaceutical Chemistry and Biochemistry.

### 4. *The Imperial Serologist*

40. The Imperial Serologist with the Government of India is provided with accommodation in the buildings of the Calcutta School of Tropical Medicine. This accommodation is very badly needed by the School itself.

Routine work consists chiefly of serological investigations undertaken for medico-legal purposes but, in addition, a large number of Wassermann reactions are performed. In addition to his routine duties the Imperial Serologist gives a limited number of lectures on serology to students of the School of Tropical Medicine and of the All-India Institute of Hygiene & Public Health.

Despite a heavy burden of routine work and very limited accommodation, a considerable volume of research work has been done in this Laboratory chiefly in relation to serological problems of medico-legal importance.

## III. MEDICAL RESEARCH IN LABORATORIES MAINTAINED BY PROVINCIAL GOVERNMENTS

### 1. *Laboratories maintained by the Government of Madras*

41. *The King Institute of Preventive Medicine, Guindy.*—The King Institute was founded as a provincial Public Health Laboratory for the Madras Presidency in 1903. The Institute itself stands in a spacious compound at Guindy, about five miles from Madras City, and consists of a main building and a group of subsidiary buildings. Additional buildings have been added from



time to time in order to provide accommodation for the gradually increasing volume of work undertaken. The accommodation available was adequate until the outbreak of the present war. Recently, sanction has been obtained for the construction of additional buildings. The accommodation provided for the routine and research activities of the Institute is well designed and well equipped.

42. The chief functions of the King Institute, Guindy, are routine public health laboratory work, advisory work and research. The routine functions include:—

- (1) The conduct of bacteriological, serological and pathological examination of specimens from all hospitals in Madras City and from Government hospitals and dispensaries throughout the Madras Presidency. Specimens are also received from Mission Hospitals.
- (2) The manufacture of bacterial vaccines used in the prophylaxis and treatment of diseases and also the manufacture of sterile solutions intended for injection.
- (3) The manufacture and distribution of therapeutic sera to various hospitals in the Presidency.
- (4) The manufacture and distribution of vaccine lymph for the use of the Public Health Department.
- (5) The conduct of public health laboratory work, such as the examination of water samples from protected and projected water-supplies in the Province.
- (6) The conduct, by the Government Analyst, of examinations of foodstuffs in connection with the administration of the Prevention of Adulteration Act.
- (7) Blood Bank for the City of Madras.

43. Advisory work is carried out on a large scale and includes technical advice to the Government of Madras, including the Medical, Public Health, Fisheries and Hydro-electric Departments in connection with medical and public health problems of all kinds and with problems connected with existing or projected water-supplies. Many other matters affecting the public health are referred to the Institute by the Public Health Department.

44. Research work has always been an important function of the Institute and among the subjects on which special research has been undertaken are: cholera, typhoid, plague, leprosy, diphtheria, virus diseases, malaria, filariasis and protozoal and helminthic diseases, and subjects relating to water-supplies, including water bacteriology, algology and endemic fluorosis.

45. A prominent feature of the work of the Institute is the maintenance of three special "Investigation Units", which being mobile, can be despatched at short notice to investigate in the field any outbreaks of epidemic disease which may occur in the districts, so that suitable preventive measures may be taken without delay. Since 1922, when the first of these units was set up, they have undertaken special inquiries on dysentery, relapsing fever, typhoid

fever, cholera, malaria, gastro-enteritis, kala-azar, filariasis, glandular fever, diphtheria, sprue, jaundice, beri-beri, meningitis, plague, stomatitis, etc.

46. The work of the Institute is organized in various sections, each of which is in charge of a specially qualified officer. There are, at present, 12 sections:—

- (1) Clinical Bacteriology and Media.
- (2) Serology.
- (3) Auto-vaccines and Stock Cultures.
- (4) Large-scale manufacture of Prophylactic Bacterial Vaccines.
- (5) Manufacture of Sterile Solutions for Injection.
- (6) Bacteriophage.
- (7) Manufacture of Vaccine Lymph.
- (8) Manufacture of Anti-toxic Sera.
- (9) Public Health Section (including water analysis, etc.).
- (10) Chemical Section.
- (11) Government Analyst.
- (12) Blood Bank and Plasma Processing Centre.

47. The work of the above sections is under the control of the Director who is assisted by 4 Assistant Directors each of whom is in charge of a group of sections. In addition, there are 15 medical officers, 15 senior non-medical assistants and a large staff of laboratory assistants, technicians, clerks, store-keepers, overseers, animal attendants, etc. The Government Analyst has his own separate staff.

Regular courses of instruction are organized at the Institute for:—

- (a) students taking the Bachelor of Sanitary Science Degree of Madras University, who receive instruction in the manufacture and use of vaccine lymph;
- (b) students undergoing training for the Government Diploma in Laboratory Sciences, who receive advanced training for one month in serological methods and
- (c) students of the Sanitary Inspector class who are given training in vaccination work.

48. In addition, special instruction is given to medical graduates in general bacteriological methods, usually for a period of three months, during which they are attached to the officer-in-charge of the appropriate section. Candidates desirous of undergoing training as laboratory attendants may be admitted for special instruction.

49. The Institute possesses a good library, the books and periodicals in which are well chosen for the type of work undertaken, namely, medicine, public health, bacteriology, parasitology, immunology, analytical chemistry, etc. The library is in charge of a trained librarian.

50. No special staff is maintained exclusively for research work; but research is undertaken by individual workers in addition to the routine duties allotted to them. A number of special research inquiries financed by the Indian Research Fund Association have been carried out at the Institute under the supervision of the Director. Most of these inquiries have, in the past, produced valuable results as, for example, the special investigations carried out on virus diseases, including vaccinia virus, sandfly fever virus, typhus, dengue, trachoma, etc.; cholera, including studies on the vibrio, epidemiology, treatment and the value of prophylactic inoculation; plague, including epidemiology and the value of prophylactic inoculation; malaria, including experimental laboratory investigations on immunology, protozoology and treatment; endemic fluorosis, the occurrence of which was first brought to notice by the Institute and the causes of which have since been elucidated; water and sewage bacteriology, some of which has been carried out under the auspices of the Water and Sewage Purification Committee; investigations on the algal flora in water-supplies originally financed by the Indian Research Fund Association and now carried out as a routine by a permanent section of the Institute. A continuous research activity is the evolution of newer and better technical methods in relation to the conduct of the routine work of the Institute.

51. It will be clear from this brief summary of the advisory, routine and research activities of the Institute and from the great expansion of its activities which has taken place over the last 40 years, that the Institute has played a very important part in the development of public health work in the Madras Presidency.

The conditions of manufacture of biological products at the Institute are of a very high standard. The section for the preparation of vaccine lymph, for example, is probably better organized and equipped than any other in India and is considered to be equal to any in existence elsewhere.

## 2. Laboratories maintained by the Government of Bombay.

52. (a) *Haffkine Institute, Bombay.*—The Haffkine Institute was opened in old Government House, Parel, in 1900 and has since been modified and extended to meet the growing needs of the Province. It is controlled and financed by the Government of Bombay.

The primary functions of the Haffkine Institute are to carry out routine public health laboratory work, to undertake the large-scale manufacture of vaccines, sera and other biological products, and to undertake research work.

The routine work of the Institute includes the large-scale manufacture of plague, cholera, T.A.B. and anti-rabic vaccines; the manufacture of anti-toxins and toxoids, including tetanus, diphtheria, and gas-gangrene anti-toxins, tetanus and diphtheria toxoids and anti-dysentery and anti-plague sera; clinical pathology for diagnostic purposes, a prominent feature of which is that work in connection with such infectious diseases as enteric, dysentery,

cerebro-spinal fever, diphtheria, typhus and malaria is carried out free, even for private practitioners; routine analyses of food and water as required by the Public Health Department of the Government of Bombay; tests on the nutritional value of foodstuffs and advice to Government; large-scale manufacture of solutions intended for parenteral injection; and the provision of a blood bank.

At the present time the Institute is organized in nine departments, namely: Vaccine Department; Serum and Anti-Toxin Department; Pharmacology Department; Biochemistry Department; Chemotherapy Department; Entomology Department; Nutrition and Experimental Pathology Department; Virus Diseases Department; and Clinical Pathology Department. In addition, there are five associated field inquiries, namely (1) treatment of plague with sulphathiazole; (2) investigation of plague in Sholapur and adjoining districts; (3) leptospirosis; (4) typhus; (5) nutritional factors in hepatic cirrhosis.

The Haffkine Institute is exceptionally well equipped both for routine and research work, and especially for public health laboratory work, the preparation of biological products, and clinical work. Special features of the Institute's equipment are constant-temperature rooms at 0°C., 4°C., 23°C., 28°C. and 37°C. Five rooms are being air-conditioned in connection with the blood bank and the preparation of anti-toxins. Ample laboratory accommodation for all purposes is available and there are excellent animal houses, including stables and paddocks for 150 horses.

The staff of the Institute includes the Director, 8 Assistant Directors, each of whom is in charge of a department, some 27 officer assistants, including graduate technicians, and an adequate subordinate staff.

The activities of the Haffkine Institute have increased rapidly in recent years and the annual budget has risen from approximately Rs. 3 lakhs to Rs. 8 lakhs. The Institute is still expanding and at the present time some Rs. 12 lakhs are being spent on improved accommodation and equipment. When this work is complete the budget will be increased. A point of particular interest is that the whole of the revenue of the Institute from sale of manufactured products and for other work is made available for maintenance and for expansion and development.

The Haffkine Institute is also a training centre for Medical and Public Health Officers and Sanitary Inspectors in anti-plague measures.

In addition to the very large volume of routine work carried out, research work is undertaken on a wide variety of subjects. No special research staff is retained but the work of the Institute is so organized that the officers in charge of the various departments and their assistants, have sufficient time to undertake research in addition to their routine duties. These officers are selected primarily on the basis of their aptitude for research work. Emphasis is placed chiefly on applied research in relation to im-

proved production of biological preparations and health problems of special importance to the Province. For many years the Institute has been the chief centre in India for the investigation of plague, and measures for its prevention and treatment. More recently research work has been extended to cover a much wider field and at the present time work is being carried out on chemotherapy, nutrition, malaria, physiology, entomology, virus diseases and other subject. Most of the research work done is financed from the Institute budget but four inquiries are financed by the Indian Research Fund Association namely, the Plague Inquiry, the work on Pharmacology of Anti-Malarial Drugs, the Typhus Inquiry and the Inquiry into Nutritional Factors in Hepatic Cirrhosis.

The Haffkine Institute provides excellent facilities for medical research because of its ample laboratory accommodation, good equipment, fine animal houses and comprehensive library. The latter contains some 12,000 bound volumes and receives over 200 journals and periodicals. Apart from its own resources the Institute also benefits from its close proximity to and association with, the Seth G. S. Medical College and a group of hospitals including the Tata Memorial Hospital with its well-equipped research laboratories. Investigations on a wide range of subjects have been carried out in recent years and a number of important contributions to the literature have been made. The Government of Bombay awards four research scholarships each year.

(b) *Public Health Laboratory, Poona.*—This laboratory is engaged in the conduct of public health laboratory work, such as chemical and bacteriological analyses of water, and is adequately equipped for routine work of this kind. No research work is undertaken and the accommodation and equipment available are not such as to make this laboratory a suitable research centre.

(c) *Vaccine Lymph Depot, Belgaum.*—Vaccine lymph is prepared from cow-calves on a large scale in accordance with accepted routine methods. The accommodation, equipment, appointments and technical conduct of the work are of a high standard. The Depot would be capable of development into a centre for virus research work.

### 3. *Laboratories maintained by the Government of Bengal.*

53. Bengal lacks an institute of preventive medicine such as the Haffkine Institute in Bombay or the King Institute in Guindy. The Government of Bengal has, however, provided for the production of essential biological products and the conduct of public health laboratory work in piecemeal fashion.

(a) *The Vaccine Lymph Depot, Calcutta.*—Primary vaccination in Bengal is compulsory, but the evidence available indicates that the arrangements for carrying it out are so unsatisfactory that only a small proportion of the infant population is vaccinated while re-vaccination in the older age-groups is an even rarer occurrence. Nevertheless, the potential requirements of vaccine lymph for the province apparently cannot be met from the Government Vaccine Lymph Depot in Calcutta during epidemic

periods and it is necessary to supplement the output of this Dépôt by obtaining additional supplies from other provinces.

The Vaccine Lymph Dépôt in Calcutta is located on the ground floor of a rented house, the upper floor of which is used for the manufacture of cholera vaccine. The buildings are in a poor state of repair, and the rooms are ill-adapted to the work, having been constructed for residential purposes. The available accommodation is insufficient, the fittings and equipment are poor, and the technical conduct of the work is not, in all respects, satisfactory. There is a spacious compound, but the housing provided for the calves in quarantine, the calves in reserve, and the calves under treatment, are badly designed and poorly equipped. For example, there are no proper stalls or fittings to prevent the vaccinated calves from lying down, or from licking themselves or each other. In brief, the conditions under which vaccine lymph is prepared in Calcutta leave a great deal to be desired. The work is carried out in a routine, rule of thumb manner and no attempt is made to conduct research or otherwise to improve the present conditions of manufacture.

The maximum output of vaccine lymph under present conditions is approximately 10 million "doses" per annum.

(b) *The Cholera Vaccine Laboratory, Calcutta.*—The Cholera Vaccine Laboratory is located on the upper floor of the rented building used for the Vaccine Lymph Dépôt. The accommodation available is quite unsuited to the work in hand and is grossly overcrowded. The rooms are mostly small, badly lighted and are in a poor state of repair. The technical conduct of the work is not, in all respects, satisfactory. Despite the many criticisms which could be made of the technique at various stages of manufacture it was claimed that contaminations rarely occurred. This is surprising considering the frequency with which contaminations occur in other Government Institutes where the conditions of manufacture are incomparably superior. The laboratory was not able to meet recent emergent demands and additional supplies had to be obtained from Government laboratories elsewhere in India and from a commercial firm in Calcutta. The difficulty experienced by this overcrowded and ill-equipped laboratory in adapting itself to greatly increased output can well be understood.

The maximum annual output is approximately 4,500,000 c.c. of vaccine. Manufacture is undertaken for only five days in each week. No research work is undertaken in this laboratory and on account of the poor accommodation and equipment available, it would be inadvisable to do so.

(c) *The Pasteur Institute, Calcutta.*—The Pasteur Institute, Calcutta, like the two laboratories referred to above, is located in a double-storied residential building. The ground floor is used for the manufacture of anti-rabic vaccine and as a treatment centre, while the upper storey is used as the Superintendent's living quarters. The buildings are in a very bad state of repair.

The anti-rabic vaccine prepared is 1 per cent. carbolyzed sheep-brain vaccine. All other institutes in India now use a 5 per

cent. sheep-brain suspension. It has frequently been suggested that the strains of rabies virus prevalent in Bengal are less virulent than those in other parts of India, and it is presumably for this reason that the Pasteur Institute, Calcutta, has not adopted the stronger vaccine. The mortality from rabies among patients treated with 1 per cent. vaccine in Bengal is no higher than that reported elsewhere in India.

The Institute is capable of producing all the anti-rabic vaccines likely to be required in Bengal and is at present turning out approximately 10,000 courses of anti-rabic treatment a year. The process of manufacture of the vaccine was not seen by us, but it was apparent from an inspection of the rooms used for the purpose, and from the information given by the Superintendent, that the conditions of manufacture could not be regarded as satisfactory.

The staff of the Institute consists of a Medical Superintendent, two medical assistants, 4 laboratory assistants and appropriate clerks and menial staff. This may be considered a generous allotment for the routine work in hand, but in spite of this no attempt is made to undertake research, or otherwise to improve methods of manufacture of the vaccine.

(d) *The Bengal Public Health Laboratory, Calcutta.*—This laboratory occupies very congested accommodation in the already overcrowded Calcutta School of Tropical Medicine. The Laboratory is concerned in the production of biologicals, only in so far as it is responsible for carrying out sterility tests on the products of other Government laboratories.

The main functions of the Laboratory are to carry out routine public health laboratory work including the chemical and bacteriological examination of water, analysis of foodstuffs sent to the Laboratory by local bodies under the provision of the Bengal Food Adulteration Act, and bacteriological work such as the special investigation of epidemic diseases and the examination of disinfectants.

The Laboratory is organized in two main sections : (1) Chemistry Section (for food and water analyses), and (2) a Bacteriological section.

The staff consists of a Director who is also professor of Public Health Laboratory Practice at the Calcutta School of Tropical Medicine, a Public Analyst, 9 Assistant Analysts (chemistry), and two Bacteriologists, together with a staff of laboratory assistants, clerks, sweepers and peons and other inferior staff. The equipment of the Laboratory is adequate for the routine duties carried out. Research has been attempted from time to time, but at present, any serious attempt at scientific investigation is effectively precluded by lack of accommodation, lack of equipment, and lack of a proper animal house.

Apart from the necessity for increased accommodation for the routine activities of the laboratory, the space at present occupied is very badly needed by the School of Tropical Medicine.

4. *Laboratories maintained by the Government of the United Provinces.*

54. In addition to the Provincial Hygiene Institute at Lucknow, provision is made for the manufacture of vaccine lymph at the Vaccine Lymph Dépôt, Patwa Dangar, near Naini Tal; laboratory work in connection with the Provincial Food Adulteration Act is carried out at the Laboratory of the Public Analyst in Lucknow; and routine medico-legal and excise work is undertaken at the Chemical Examiner's Laboratory, Agra. These various organizations perform the functions of one of the larger provincial institutes, such as the King Institute, Guindy.

(a) *The Provincial Hygiene Institute, Lucknow.*—The Provincial Hygiene Institute, Lucknow, is housed in a modern, well-constructed building immediately adjacent to the King George Medical College, Lucknow. In the early years of its existence, courses for the Diploma in Public Health were held but these were discontinued when the All-India Institute of Hygiene and Public Health was opened at Calcutta. Courses of instruction are still given to Officers and sanitary inspectors of the Provincial Public Health Service; students of the medical college and health visitors also receive instruction in hygiene at the Institute. The staff of the Institute, though small, is well qualified, and experienced in the type of work undertaken. Accommodation and equipment are barely sufficient for present needs. In addition to routine public health laboratory work the Institute meets the demands for cholera vaccine for the entire Province, and at present provides accommodation for the Provincial Blood Bank. These two latter activities were not envisaged when the Institute was built sixteen years ago, with the result that the available accommodation is already becoming overcrowded. There is, however, ample room for expansion.

Manufacture of cholera vaccine at the Institute was commenced in 1931 and the annual output is now approximately 1,000,000 doses a year. The rooms allotted for this work provide sufficient accommodation; the equipment is good and the supervision and technical conduct of the work are of a high standard.

An important function of the Institute is to undertake special investigations into public health problems in the field as occasion demands. For this purpose a team of selected workers is mobilized, the selection of the workers and the equipment taken depending upon the nature and extent of the problem to be investigated. In the past, outbreaks of epidemic dropsy, meningitis, cholera, plague, food-poisoning, etc., have been investigated in this way. Research work has also been carried out at the Institute itself during recent years, the subjects studied including standards for turbidity of raw water admitted to filter-beds; researches on typhoid fever; work in connection with helminthic surveys at the Health Unit, Partabgarh, and at the sewage farms at Allahabad and Lucknow. There is a small library in the Institute which consists mainly of standard textbooks and a limited number of public health periodicals; the Medical College library is available for consultation in a nearby building.



(b) *The Vaccine Lymph Depôt, Patwa Dangar*, is ideally situated among beautiful surroundings at an elevation of 5,300 ft. The Depôt consists of laboratories, animal houses and residential buildings scattered over an estate of some 23 acres and is completely self-contained. Its sole function is to manufacture and issue all vaccine lymph requirements for the Province. Maximum output is about 3,700,000 "doses" per annum. Manufacture is normally carried out only from 1st October to 31st December each year. Experience has shown that manufacture can be continued satisfactorily from October to March inclusive but that the yield and quality of lymph is poorer during the hotter months of the year. Lymph is prepared from bull-buffalo calves but in other respects the methods employed are those in common use elsewhere. The process of manufacture was not observed. Before issue the lymph is subjected to bacteriological examination and is tested for potency on animals as well as by field trial at selected centres. Accommodation and equipment are reasonably satisfactory for routine work. No research work is done but there is ample room for expansion for this purpose. Supplies of water and electricity are obtained from Naini Tal but the lack of a gas supply is a notable defect.

(c) *The Chemical Examiners' Laboratory, Agra*, is housed in a residential building. Accommodation is insufficient for the wide range of routine functions performed. A notable deficiency is the absence of an animal house. Equipment is reasonably satisfactory for most of the routine work undertaken but the laboratory lacks a spectrograph ultra-violet apparatus, X-ray, large-scale extractors, muffle furnace, etc. Facilities for research are practically non-existent at the present time owing to lack of accommodation and heavy pressure of routine work. Library facilities are very meagre. Despite these handicaps some research work is in progress chiefly in relation to the improvement of routine procedures followed in the Laboratory. The Chemical Examiner expressed the opinion that medico-legal work in India is carried out in a most unsatisfactory manner and emphasized the need for a central institute to undertake research and provide a training centre for this important subject.

(d) *The Public Analyst's Laboratory, Lucknow*.—The Professor of Chemistry, University of Lucknow, holds the office of Public Analyst and accommodation is found within the Department of Chemistry. He is assisted by one whole-time Assistant Public Analyst and seven or eight Analyst Assistants. Routine work is confined to analysis of foodstuffs under the Provincial Food Adulteration Act. Accommodation is very limited and equipment, while good for most of the routine work, is deficient as regards a spectroscope, ultra-violet apparatus and vitamin-estimation apparatus. Owing to heavy routine duties, lack of space and equipment, research is not undertaken apart from occasional investigations for the solution of specific problems referred to the Laboratory. In the opinion of the Public Analyst and his assistants, research is badly needed to evolve better methods for the

detection of food adulteration, for the quantitative estimation of certain ingredients, and to establish standards. In regard to the latter the need for research has been stressed by a special committee of the Central Advisory Board of Health in a report published in 1939.

(e) *Provincial Blood Bank, Lucknow.*—The Provincial Blood Bank was opened in 1942 under the technical direction of the Professor of Pathology, Medical College, Lucknow. Its main functions are to collect, process, store and supply transfusion material to hospitals and dispensaries and to train medical officers in approved methods of blood transfusion and blood matching. The main processing centre is located in the Provincial Hygiene Institute and is well staffed and equipped.

#### 5. *Laboratories maintained by the Government of the Punjab*

55. Although the Punjab lacks an Institute of Preventive Medicine organized on as broad a basis as the Haffkine Institute, Bombay, or the King Institute, Guindy, most of the functions performed by one of the larger institutes are provided for in one or other of the following laboratories:—

- (a) The Punjab Epidemiological Laboratory, Lahore.
- (b) The Vaccine Institute, Lahore.
- (c) The Punjab Provincial Bacteriological Laboratory, Lahore.
- (d) The Chemical Examiner's Laboratory, Lahore.

The Central Research Institute, Kasauli, although a central government institution, is situated in the Punjab and supplies the Province's requirements of vaccines and sera.

(a) *The Punjab Epidemiological Laboratory, Lahore*, is accommodated in buildings of the King Edward Medical College, Lahore. The Laboratory performs the routine functions of a public health laboratory and is well equipped for this purpose. In addition, it functions as an investigation and advisory bureau for the Provincial Public Health Department and serves as a training centre for sanitary inspectors. Investigation units have been mobilized from the resources of the Laboratory from time to time and important field inquiries have been undertaken in this way especially on hookworm, malaria and cholera. Special units are set up from time to time in connection with large fairs. The Laboratory issues an annual forecast of the probable occurrence of epidemic malaria in various parts of the Province and performs the functions ordinarily undertaken by a Public Analyst's laboratory.

(b) *The Vaccine Institute, Lahore*, is concerned chiefly with the production of vaccine lymph to meet the needs of the Province. Supplies are also made to other areas including Afghanistan and Persia. Accommodation and equipment are satisfactory for the production of vaccine lymph according to recognized routine procedures. Buffalo-calves are used. Research work is also carried out, an example of which is the cultivation of vaccine virus on chick embryo.

(c) *The Punjab Provincial Bacteriological Laboratory, Lahore*, is a diagnostic laboratory which undertakes clinical, pathological and histological examinations for the Province as a whole.

(d) *The Chemical Examiner's Laboratory, Lahore*, performs routine medico-legal work, and, in addition, undertakes analysis of foodstuffs.

(e) *Mobile Research Laboratory, Lahore*.—The Government of the Punjab has recently sanctioned the creation of a Mobile Research Laboratory with its own separate staff and equipment which will be based on the Pathology Department of the King Edward Medical College. This unit will be available to undertake field investigations any where in the Province and the intention is that it should spend as much time as may be necessary to investigate the particular problem in hand. The staff of this Mobile Laboratory will undertake all of the field investigations necessary, and, in addition, will collect material which can be more exhaustively investigated in the Department of Pathology or in any other department of the Medical College. The policy regarding the use of this Mobile Laboratory will be laid down by a small committee consisting of the Inspector-General, (Civil Hospitals), the Director of Public Health and the Principal of the Medical College.

#### 6. Laboratories maintained by the Government of Assam.

56. (a) *The Pasteur Institute and Medical Research Institute, Shillong*.—The proposal to establish a Pasteur Institute in Assam was first put forward in 1906 by the Assam Branch of the Indian Tea Association. The continued efforts of this Association in this direction resulted, in 1910, in the allocation of a part of the King Edward VII Memorial Fund for the construction of an institute. This was supplemented later by a grant of Rs. 40,000 from the Indian Research Fund Association to establish a library and provide equipment for the Institute. The buildings were completed and the Institute opened as an anti-rabic treatment centre at Shillong in 1917. At the present time the main institute and certain auxiliaries are located on the outskirts of Shillong at an elevation of about 5,000 ft. The institute buildings are situated in a compound about 10 acres in extent. The institute and its auxiliaries consist of:—

- (1) The main laboratory.
- (2) A clinical research hospital with some 20 beds.
- (3) A malaria training centre connected with the Research Section of the Assam Medical Research Society.

There are good staff quarters, animal houses, etc., and the large compound offers space for considerable future expansion.

The work of the Institute is organized in three main sections:—

- (1) *Rabies Section*.—This provides a centre for anti-rabic treatment at which some 2,500 patients are treated annually. Medical Officers in charge of public and private anti-rabic treatment centres are trained here.

Large-scale manufacture of anti-rabic vaccine is undertaken and supplied to the ever-increasing number of treatment centres throughout the Province.

- (2) *Laboratory Diagnosis Section*.—The Institute serves as a Provincial Laboratory for routine diagnostic work including microscopical, cultural and serological work and the histological examination of tissues. Over 4,000 examinations of this kind are carried out annually.
- (3) *Vaccine Manufacturing Section*.—This section is engaged chiefly in the large-scale manufacture of prophylactic cholera and T. A. B. vaccines to meet the needs of the Province. The preparation of a combined cholera-dysentery bacteriophage is undertaken on a large scale and this product is supplied not only to Assam but also to practically the whole of India. Demands for these products are very variable and it is necessary to maintain large reserves to meet the excessively high demands received during epidemics. In 1935 and again in 1936, nearly one million ampoules of cholera bacteriophage were issued, while in 1938 nearly one million c.c. of cholera vaccine were issued.

The small clinical research hospital is an important part of the Institute and a great deal of experimental work has been carried out in it, principally on the treatment of kala-azar by antimony compounds, and on the treatment of cholera and dysentery by bacteriophage.

In 1930, the Research Section of the Assam Medical Research Society was established at the Institute and since that time considerable work on the epidemiology, prevention and treatment of cholera and on the control of malaria in the field, has been carried out.

The officers of the Institute have always been members of the Medical Research Department. The standards maintained in the production of biological preparations are on a par with other central and provincial institutes similarly staffed. The interchange of officers between these institutes has resulted in the dissemination of the best and most up-to-date procedures among the various institutes.

The Pasteur Institute, Shillong, has a good record in the field of research. This has been carried out principally on diseases of particular importance to Assam, especially kala-azar, cholera, dysentery, malaria, Naga sores, etc. Among the better known of these researches may be cited the work of Shortt, Knowles and others on the treatment of kala-azar and on the transmission of this disease by the sandfly; the work of Morrison on the treatment of cholera and dysentery by bacteriophage, and on the technique for large-scale manufacture of this product evolved by him; and the work of Rice and others on the investigation and control of malaria in Assam. The Institute has also played an important part in the 8-year programme of cholera research

financed by the Indian Research Fund Association. The part played in these investigations by members of the staff of the Institute, including Anderson, Pandit and others, concerned chiefly the isolation of various types of cholera 'phage and their influence on the characters of *V. cholerae*.

(b) *The Provincial Public Health Laboratory, Shillong*, is closely linked with the Pasteur Institute though it is not an integral part of it. This laboratory carries out routine analyses of food, water, etc.

#### IV. MEDICAL RESEARCH IN TEACHING INSTITUTIONS.

##### 1. *Post-graduate Teaching Institutions.*

57. (a) *School of Tropical Medicine, Calcutta*.—The School of Tropical Medicine was founded through the initiative of Major-General Sir Leonard Rogers, I.M.S., and was opened in Calcutta in 1922. The teaching facilities available depend on (1) the School proper which is housed in a well-designed and constructed four-storey block, properly equipped to undertake teaching and research on a wide variety of subjects, and (2) a small but well-designed and equipped Hospital (Carmichael Hospital for Tropical Diseases) which provides beds for over one hundred men, women and children suffering from a varied selection of tropical diseases. The patients admitted to this hospital are carefully selected so as to provide a representative range of clinical material for teaching and research. Approximately 1,000 in-patients and 25,000 out-patients are treated at the hospital every year. The facilities thus provided for teaching and research on tropical diseases are probably unrivalled in any part of the world.

The buildings for the School proper were erected by the Government of Bengal who received a grant of Rs. 5 lakhs towards the initial cost from the Government of India. Funds for the erection of the Hospital for Tropical Diseases and for the conduct of research were collected from public and private sources by Sir Leonard Rogers. At the present time, certain departments of the School are staffed and maintained by the Government of Bengal, while others are financed largely from the Endowment Fund of the School or from considerable sums of money donated each year by various industrial concerns. A number of research inquiries are also financed by the Indian Research Fund Association. The activities of the School have expanded rapidly till at the present time there are nearly 20 departments, each busily engaged in the conduct of research in addition to routine teaching work. The research work undertaken covers tropical medicine, pharmacology, entomology, chemistry, pathology, bacteriology, protozoology, hæmatology, diabetes, filariasis, helminthology, dermatology, kala-azar, leprosy, bowel diseases, indigenous drugs, nutrition, etc.

Each of the subjects enumerated appears to enjoy the status of a separate department. The Professor of Tropical Medicine acts as co-ordinator of research. The School has a fine record of research work covering a very wide range of subjects. Much of the

work done has a clinical bearing and this is of particular importance inasmuch as many of the other institutions in India engaged on medical research are largely or entirely divorced from clinical material.

Every department of the School is, at present, suffering acutely from lack of adequate accommodation and it is true to say that the work being carried out is seriously handicapped by lack of space. The various departments of the School are at present so overcrowded that it would be impossible for them to accommodate any appreciable number of graduates for advanced training in research.

The School is primarily a teaching institution and courses of instruction are given which are particularly suited to the needs of India. Two courses of instruction are given each year: one of six months' duration for admission to the Diploma of Tropical Medicine of the Faculty of Medicine and Hygiene, Bengal; the other of three months' duration for the examination of Licentiate in Tropical Medicine of the same Faculty. Admission to the longer course (D. T. M.) is, in general, confined to persons holding medical qualifications recognized by the General Medical Council of Great Britain and to Government Medical Officers. Admission is decided by a special Selection Committee at the School.

The School also admits qualified students desirous of undertaking special lines of study or research for periods not exceeding six months, provided that the attendance of such students does not interfere with the prescribed courses of study, and subject to the approval of the Surgeon-General with the Government of Bengal.

Three courses, each of two weeks' duration, are arranged each year for the post-graduate study of leprosy and these courses are sponsored by the Indian Council of the British Empire Leprosy Relief Association.

In addition to the regular teaching at the School, lectures and demonstrations on protozoology and helminthology are given by members of the staff to students attending the D.P.H. courses at the All-India Institute of Hygiene and Public Health.

Since the beginning of the war, the School has organized special intensive courses of instruction in tropical medicine for specialists in medicine of the British and American armies, and up to the present time over one hundred officers have received instruction in this way. A limited number of officers have also been admitted to individual laboratories of the School for instruction in special-subjects.

The School of Tropical Medicine provides one of the few examples in India where advanced teaching and research are carried out side by side, where advantage is taken of the excellent clinical material available, and where students are trained in an atmosphere of research work.

(b) *The All-India Institute of Hygiene and Public Health.*—This Institute is housed in a modern, well-equipped building

immediately adjacent to the Calcutta School of Tropical Medicine. It is staffed and maintained by the Government of India.

The Institute was opened in 1932, for the purposes of "investigating methods of applying knowledge for medical protection to large groups of the community" and of training students in these methods. There are six teaching sections, namely:—

- (i) Public Health Administration.
- (ii) Vital Statistics and Epidemiology.
- (iii) Microbiology (including bacteriology; immunology and serology; filterable viruses and the rickettsias; medical entomology; protozoology and helminthology).
- (iv) Biochemistry, Nutrition and Physiological Hygiene (including public health chemistry and physiology applied to public health).
- (v) Sanitary Engineering.
- (vi) Maternity and Child Welfare.

Regular Post-graduate courses are held leading to the following diplomas: D.P.H.; D.P.H. & Hy.; D.M.C.W. Facilities are also available for students to prepare for the D.Sc. degree in public health of the Calcutta University. In addition, special courses are offered by each teaching section for workers desirous of undergoing training in a particular subject, and, since the Institute was opened, twelve such courses have been given. The Institute collaborates with the School of Tropical Medicine in its regular courses.

The laboratories, lecture theatres and museum are, in normal times, well adapted for teaching and research. At present a considerable proportion of the available accommodation has been given over for emergency work, particularly for the Calcutta Blood Bank and for the large volume of routine work undertaken on behalf of the Defence Department by the Biochemical Standardization Laboratory which is temporarily housed in the Institute. The facilities for teaching and research are enhanced by the opportunities provided for demonstrations, teaching and research at the Health Centre, Singur. The library contains some 12,000 bound volumes and receives 124 journals selected so as to be complementary to, and avoid overlap with, those received in the library of the School of Tropical Medicine.

Special attention is now being given to the development of the primary function of the Institute, namely, the establishment of a controlled experimental area where methods of applying knowledge to large community groups can be investigated. The area selected for this purpose centres round the Health Centre at Singur. The scheme is a collaborative one between the Government of India and the Government of Bengal and administrative responsibility for it is vested in the Institute. It will thus be possible for the various sections of the Institute to undertake investigations on methods of applying knowledge of their particular subjects to large communities. The various sections of the Institute, as at present

constituted, are not sufficiently comprehensive to cover all aspects of public health. New sections of Physiological Hygiene and Industrial Hygiene are required and the Sanitary Engineering Section requires to be strengthened in view of the primary importance of environment on health, particularly in India.

The work of the Institute is so organized that the staff of each section has ample time for research—probably as much as two-thirds of their time. In the decade since the Institute commenced to function, some 100 scientific papers have been published on a variety of subjects including epidemic dropsy, malaria, tuberculosis, kala-azar, nutrition, biochemistry and the clinical aspects of maternity and child welfare. Opportunities for research are exceptionally favourable because of good accommodation and equipment, ample material both in the laboratory and in the field, and adequate library facilities.

## 2. *The Medical Colleges.*

58. In Western countries, medical research is undertaken chiefly in the various departments of the universities, medical colleges and teaching hospitals. Research is, in fact, an almost universal activity in such institutions and is regarded as a normal function. Additional funds for research work are often made available by grants-in-aid from public or private sources or from endowment funds.

Broadly speaking, medical research receives little or no attention in the medical colleges of India. There are, of course, exceptions to this general rule. It is probable that the lack of research, which has been universally admitted, is due to a complexity of factors, the most important of which will be discussed below.

The authorities responsible for staffing and financing the medical colleges are usually ignorant of the importance of research in relation to the achievement of a high standard of teaching and the development of a correct attitude of mind in the student. This point has been stressed by many witnesses whom we interviewed and, in the words of one of them, "Research has never been an active interest of Government organizations and facilities for it have had to be slowly wrung out of unwilling administrators. Schemes for the advancement of learning or research are usually shelved under the plea of financial stringency, unless the authorities are stimulated into action by such major catastrophes as wars or epidemics". In India the vision of the authorities in this respect has been even more limited than in many other countries. As a result of this ignorance and lack of interest at the top, the practice has been to restrict the teaching staff of individual departments to the minimum necessary for the conduct of routine teaching duties and, in some cases, provision for these has been inadequate. In many cases the authorities have, in their efforts to curtail expenditure, not only reduced teaching staff below an efficiency level but have reduced their emoluments below a reasonable living wage. Teachers in the medical colleges have consequently been compelled to indulge in private practice in order to



supplement their incomes with the result that their interests and energies have been diverted from academic pursuits.

In the opinion of some witnesses lack of research is due primarily to the absence of adequate accommodation and equipment; others maintained that a potent cause was to be found in the failure to recruit the right type of men; and others again cited over-security of tenure in teaching appointments as a strong contributory factor since this removed incentive to original investigation. In his evidence, Professor A. V. Hill, Secretary of the Royal Society, said that in the medical colleges which he had visited since coming to India research was almost non-existent. In the pre-clinical subjects the head of the department was often the only member of the staff who was adequately paid. The number of assistants was in most cases, insufficient and even those available were so poorly paid that they were compelled to supplement their incomes by private practice. In the clinical subjects the greater part of the teaching was done by part-time workers most of whom were engaged in lucrative private practice. Individual members of the Committee expressed their general agreement with Professor Hill's appreciation of the situation.

During our visits to the different medical colleges in India the impressions we formed have, in general, confirmed the generalisations made above and have emphasised the complexity and variability of the factors responsible for the absence of research in these colleges. Speaking generally, medical students in this country complete their studies without coming into contact with planned scientific investigation. This serious deficiency in their training is, in our view, of even greater importance than failure to advance knowledge of the subjects concerned.

We shall now make a few remarks regarding individual institutions.

In the Calcutta Medical College the teaching of chemistry is at present a part-time activity of the Chemical Examiner to the Government of Bengal whose heavy burden of routine work takes up so much of the accommodation available and absorbs so much of his time that research is virtually impossible. This is perhaps the most extreme example in this college though the same tendency was observed in the Pathology Department. In some of the other departments lack of accommodation was not found to be a primary factor in preventing the development of research but some other factor would militate against research as, for example, lack of suitable equipment, insufficient assistants, or even absence of incentive on the part of the head of the department.

The record of research in the Madras Medical College shows clearly that the output has varied in accordance with the energy and enthusiasm of individual workers. Thus, in the Anatomy Department 20 of the 25 papers published were contributed by one author, while in the Department of Operative Surgery one individual has been responsible for all of the 56 papers published. This College now maintains a "Research Department" the activities of which are directed mainly to work on indigenous drugs

but work on other subjects, such as hormones, is also being carried out. Very little clinical research, in the true sense of the term, has been undertaken. An investigation on chronic fluorine poisoning in which the clinical, radiology and biochemistry departments co-operated provides a notable exception. In this college research is not limited so much by lack of accommodation and equipment as by the heavy teaching duties and other extra-academic responsibilities which the professors and their assistants are required to undertake. Nevertheless, it is apparent from the sporadic research activities of enthusiastic individuals that it is not impossible to attempt research, even though conditions may not be suitable for organized team work.

The same remarks apply in general to the Stanley Medical College, Madras, which has recently been raised from the status of school to college. In this college, however, accommodation and equipment are poorer. The only department in which any appreciable amount of research has been attempted is Surgery from which 66 papers have been published, all of them having been contributed by a single individual.

The Vellore Medical College, like the Stanley Medical College, has recently been converted from a medical school into a college. This College is staffed by enthusiastic workers and is likely to develop as an active research centre. New modern buildings have been provided but, owing to war conditions, these have not yet been adequately equipped for research.

The Agra Medical College has recently been raised from the old Agra Medical School but it is at present so short of accommodation and so poorly equipped that it would be impossible to undertake research on any appreciable scale. In some departments there is undoubtedly a genuine desire to do research work but it would be difficult to conceive of University departments with fewer facilities for it. In the Pathology Department, for example, the professor's room is a short length of enclosed verandah while the reader and demonstrators share a room used also as a routine diagnostic laboratory. Other departments are little, if any, better.

King George Medical College, Lucknow, is in every respect better suited for research. This college is under the direct control of the University of Lucknow and this may help to account for greater research activity than in most other medical colleges in India. In most departments accommodation and equipment are limited and routine teaching duties are heavy but despite these handicaps, research work on a restricted scale is attempted in each of the pre-clinical departments. There is abundant clinical material in the hospital associated with the College but little opportunity for research.

Research has never been a major activity in the Lady Hardinge Medical College for Women, Delhi. The staff of the various departments are so limited that those available are fully occupied with teaching and other routine duties. In the hospital attached to the College the physicians and surgeons are so busily engaged

with hospital routine and teaching that there is little opportunity for research. Apart from these difficulties, the heads of the various departments have from time to time been persons with little or no training for, or experience in, research work. Commendable efforts have, however, been made to conduct research in physiology and biochemistry.

Important research work has been done in the Seth G. S. Medical College, Bombay, especially in the Departments of Physiology and Pathology. In the former, researches on nutrition have been carried out with the aid of grants from the Indian Research Fund Association, although the accommodation and equipment available in this department are extremely limited. In the Pathology Department accommodation is more spacious, equipment is good, and there is a full complement of wholetime teaching staff. Important research work has been done since this department was re-organized by Dr. Khanolkar. The Departments of Anatomy and Pharmacology provide few facilities for research owing to shortage of staff and lack of accommodation. The equipment in the latter department is good but accommodation is so limited that it is not possible to make the best use of it. All of the teachers in the Clinical Departments of this College are part-time workers receiving honoraria with the result that they find time only to fulfil their obligations for the routine teaching of their students. The Grant Medical College, Bombay, has the benefit of more spacious accommodation in the pre-clinical departments but, in most cases, the equipment available is unsatisfactory for research work.

In the King Edward Medical College, Lahore, accommodation is sufficiently liberal to allow of a limited amount of research work and equipment is, on the whole, satisfactory. The chief impediment to the development of research in this college has been an insufficiency of personnel. Research work has been undertaken sporadically on a variety of subjects in the Departments of Anatomy, Physiology, Pathology and Pharmacology and, in some cases, grants have been received from the Indian Research Fund Association. At the present time research work is being done in the Anatomy and Pharmacology Departments. Research on nutrition problems is at present in progress in the Chemistry Department of the Punjab University. There are two other medical colleges in the Punjab, namely, the Balak Ram Medical College, Lahore, and the Glancy Medical College, Amritsar. The former has only recently been founded and is not yet staffed and equipped for research work, while the latter has recently been raised from the status of school to college.

It is clear from this brief survey of representative medical colleges that research receives very little attention. It is significant, however, that in spite of many apparent difficulties enthusiastic individuals have found it possible to devote much time and energy to research. This lends support to the evidence of some witnesses that one of the chief reasons for the absence of research is inaptitude or lack of initiative, incentive and enthusiasm on

the part of many of the teachers employed. It is noteworthy that very few inquiries under the Indian Research Fund Association have been undertaken in departments of the medical colleges. Many of the difficulties in the way of research, such as insufficient assistance, equipment and material, could be overcome if the assistance of the Indian Research Fund Association were sought.

### 3. *The Medical Schools*

59. The remarks made above regarding research in the medical colleges of India apply even more forcibly to the medical schools. Accommodation and equipment are much poorer than in the colleges and the teachers employed are, on the whole, less highly qualified.

## V. MEDICAL RESEARCH FINANCED BY THE INDIAN RESEARCH FUND ASSOCIATION.

### 1. *Malaria Institute of India (Research Section).*

60. As has been indicated above, the Malaria Institute of India was originally founded and maintained by the Indian Research Fund Association. In 1940, the public health activities of this organization were taken over by the Government of India and the research functions continued to be financed by the Indian Research Fund Association. The so-called public health and research functions of this Institute are so closely integrated that their separation is in reality impossible. The research functions of the Institute have already been dealt with under the heading "Malaria Institute of India" in that section of this Report which deals with Central and Provincial Laboratories.

### 2. *Nutrition Research Laboratories, Coonoor.*

61. These Laboratories are housed partly in the Pasteur Institute, Coonoor, and partly in buildings about 100 yards from the Institute. The latter buildings were constructed originally as a jam factory but have since been extensively re-modelled and expanded to make them suitable for laboratory work and the housing of experimental animals. Existing accommodation may be regarded as adequate for present needs and limited space is available for further expansion. The laboratories are well equipped for nutrition research work. In normal times such apparatus as is necessary for particular lines of work is easily obtained but since the war it has been difficult to procure new apparatus from abroad or to repair existing equipment which has gone out of order.

The staff of the laboratories at present consists of a Director, Assistant Director, and seven or eight research workers including chemists, biochemists and medical workers. There are five laboratory assistants, six laboratory attendants, three clerks and some 14 inferior servants, mainly animal attendants.

The laboratories possess a good collection of books on nutrition and receive an adequate selection of periodicals. They also share the extensive library of the Pasteur Institute and the library resources thus provided are adequate for the work undertaken.

The chief functions of the laboratories are to conduct research on problems of nutrition, to act as an advisory bureau on all questions of nutrition, to do a limited amount of routine work, and to hold annual courses on nutrition.

The research activities of the Nutrition Research Laboratories are well known all over the world. The credit for their development belongs to Major-General Sir Robert McCarrison, I.M.S. (retd.), who first outlined, and demonstrated the importance of nutritional problems in India. McCarrison's work began with an investigation of the effects of faulty diet on the thyroid gland but he subsequently extended the range of his researches to cover the pathological changes caused by defective diet in most of the organs of the body. McCarrison's earlier work was financed by the Indian Research Fund Association as "Beri-beri Inquiry" and later as the "Deficiency Diseases Inquiry" and it was not until 1925 that the "Nutrition Research Laboratories" were established on a semi-permanent basis. Since 1925, the research activities of the Laboratories have been progressively extended. Considerable attention has been given to the study of the nutritive value of foodstuffs and data have been compiled regarding the content in most common Indian foods of calories, protein, fat, carbohydrate, calcium, phosphorous, iron, vitamins, etc. Dietary surveys have been carried out in many parts of the country and the state of nutrition in children has been extensively studied. Diseases related to nutrition, such as keratomalacia and stomatitis, have also been investigated. In later years the scope of nutrition research has become progressively wider and during the past decade some 150 scientific papers, covering many aspects of the nutrition problem, have been published. Research has suffered since the war owing to trained workers taking up military service. Work has, however, continued and the present research programme includes further investigations on the nutritive value of foodstuffs, methods of vitamin testing, basic nutritional research, animal experimentation and clinical investigations.

Advisory work has become a heavy burden on the Director of the Laboratories. All requests for information and advice are carefully considered, the literature on the subject scrutinized, and every effort is made to provide accurate replies which will be of practical value to the inquirer. Advice is sought by the Public Health Commissioner with the Government of India, by the Department of Food, by various Central and Provincial Government Departments, by commercial organizations concerned with the feeding of labour, by missionary organizations, etc. The Director is also Honorary Consultant in Nutrition to General Headquarters, India.

At present the routine work of the Laboratories includes vitamin testing on behalf of the Inspectorate of Foodstuffs and the Department of Food as well as other Central or Provincial Government Departments. Samples of fish-liver oils are tested for vitamin A. Generally speaking, tests are carried out only on foods which are of importance in connection with the food

situation in the country or with the war. Tests are not done for commercial organizations although requests for such are frequently received.

A course of instruction on nutrition lasting about 10 weeks is held annually, usually in the months April to June. These courses have been attended by health officers, medical practitioners, agricultural officers, senior nurses, school teachers, etc. Up to the present, eight such courses have been held. Post-graduate students from other research organizations are occasionally admitted for periods of a few months for special studies, but normally voluntary workers are not provided with facilities to work on nutrition problems. Two research scholars, provided for under the Parlakimedi Trust Fund, are employed for three-year periods with the object of training young workers in nutrition.

In order to educate the public in nutrition, three popular bulletins have been published in the Government of India Health Bulletin Series. One of these, "The Nutritive Value of Indian Foods and the Planning of Satisfactory Diets" has achieved a wide circulation and has run into three editions. General articles are published from time to time in medical and other journals. Lectures and broadcasts are given as opportunity occurs. A nutrition museum is maintained in the Laboratories and attracts numerous visitors. By such means the results of nutrition research are brought to the attention of the public.

### 3. Regional Nutrition Research Units.

62. On the advice of the Nutrition Advisory Committee, the Governing Body of the Indian Research Fund Association recently sanctioned the creation of two Nutrition Research Units, one at Bombay and the other at Dacca. The establishment of these two units followed naturally on the continuous series of investigations on nutrition carried out at these two centres under the auspices of the Indian Research Fund Association for a number of years past.

Research on nutrition has been undertaken in the Physiology Department of the Seth G. S. Medical College, Bombay, for the past fifteen years. These researches were, to a large extent, financed by the Indian Research Fund Association and covered a wide field of investigation, especially on the nutritive value of pulse protein; cheap, balanced diets; nutritive value of fish, including vitamin content of liver oils obtained from them; the effect of parching on pulses and cereals; calcium metabolism; requirements of dietary fat in the tropics; nutritive value of soya bean, etc. Nutrition inquiries under the Indian Research Fund Association were formerly carried out independently by Dr. S. P. Niyogi and Dr. V. N. Patwardhan. With the creation of a Nutrition Research Unit at Bombay these inquiries have been amalgamated under the joint direction of these two workers. The staff of the Unit consists of three research assistants, one laboratory assistant and two laboratory attendants, in addition to the joint directors. The unit is based on the Physiology Department of the Seth G. S.

Medical College. The accommodation and equipment available to this Unit are very limited at present and if this Unit is to attain adequate status as a regional centre for nutrition research, it will be necessary to provide increased accommodation, greatly improved equipment and much better facilities for experimental animals. The Unit at Dacca is organized on similar lines. The annual grant for each of these Nutrition Research Units has been fixed at Rs. 12,000 per annum in the first instance. The Units will follow a plan already adopted by the Nutrition Advisory Committee and will pay special attention to problems of local importance. In the first instance researches will be carried out on the composition of the lesser known foodstuffs consumed locally and the influence of various cooking processes on the more important food constituents.

The Indian Research Fund Association has also financed numerous other inquiries on nutritional problems at various centres throughout the country.

#### *4. Miscellaneous Inquiries under the Indian Research Fund Association.*

63. Since its inception in 1911, the Indian Research Fund Association has financed a large number of special laboratory and field inquiries on a very wide variety of subjects. Applications for grants for research on any subject with a medical or public health bearing may be submitted by any suitably qualified and experienced person who has the necessary facilities for carrying out the proposed programme of work. As has been indicated above, some of the inquiries originally instituted under the Indian Research Fund Association developed so successfully that they became semi-permanent in character, and, in one case (the Malaria Survey of India) was ultimately taken over in part and constituted as a permanent Central Government Institution. Reference has already been made to the Nutrition Research Laboratories, Coonoor, which have attained a position of virtual permanency. The Kala-azar Commission, which was originally constituted on the recommendation of the Scientific Advisory Board of the Association, continued to carry out an extended investigation on this disease for nearly a decade. Similarly, a special inquiry on cholera was set up and continued to function for 8 years. A large part of the Association's activities have, however, been carried out by making grants-in-aid to research programmes put forward by individual workers. Such grants have been given not only to workers on the staff of Government laboratories and teaching institutions, but also to workers in universities, medical colleges, and other laboratories, or to workers in the field.

All applications for grants for research work are carefully considered by the Scientific Advisory Board and by the Advisory Committees constituted by this Board, and it has often been claimed that no reasonable proposal for research has ever been turned down.

Applications for grants from the Indian Research Fund Association have been received mostly from workers on the staff of Government laboratories and teaching institutions, and comparatively rarely from departments of the universities and medical colleges in India. The reasons for the paucity of applications received from departments of medical colleges in India have been considered elsewhere in this Report.

Special inquiries under the Indian Research Fund Association enjoy a freedom from official interference, which has made research work under the Association very popular with officers in Central and Provincial Government laboratories. The work achieved is subject to annual review, and so long as there is evidence that the investigations have been energetically pursued and remain promising, grants are ordinarily continued from year to year.

The system of giving grants-in-aid to research workers whose emoluments are found from other sources has released the bulk of the Association's funds for the provision of extra technical assistants, specialized apparatus and equipment, experimental animals, etc., for the work undertaken.

One of the great benefits of the Indian Research Fund Association is that money can be made available for research work at short notice without the delays ordinarily occasioned by obtaining sanction for the release of funds directly from Government sources. Recently, for example, it has been possible to set up almost immediately special investigations into the care and treatment of sick destitutes during the famine in Bengal and also to establish, at short notice, an inquiry into typhus fever in various parts of India.

Within the limits of the financial resources of the Association, the numerous inquiries which it has financed have done much to bring to light knowledge which has proved of real importance in the epidemiology, mode of transmission, diagnosis, treatment and investigation of many of the more important diseases in India. Inquiries financed by the Association over the past 20 years have also helped to elucidate the resources of the country in regard to the use of indigenous drugs.

## VI. MEDICAL RESEARCH CARRIED OUT BY OTHER ORGANIZATIONS.

### 1. *The Pasteur Institute of Southern India, Coonoor.*

64. The Pasteur Institute of Southern India was opened at Coonoor, Nilgiris District, in 1907. The major portion of the necessary funds was provided through the munificence of Mr. Henry Phipps, an American Philanthropist.

The Institute is the property of the Pasteur Institute Association which is a body registered under the Societies Registration Act of 1860. The management of the affairs of the Association is vested in a Central Committee of which the Surgeon-General with the Government of Madras is Chairman and the Director of the Institute is Secretary.



During the early years of its existence, the Institute was maintained to a large extent by voluntary contributions, although the salaries of the Director and other medical staff were borne by the Government of Madras. Revenue from the sale of anti-rabic vaccine and from the conduct of diagnostic laboratory work gradually increased and the Institute is now entirely self-supporting. For a time the financial affairs of the Association were so flourishing that a reserve fund of some Rs. 8 lakhs was accumulated. The Government of Madras then withdrew the payment of the emoluments of the medical staff of the Institute but continued to support it by the purchase of all their supplies of anti-rabic vaccine.

The Institute itself is a very well-constructed double-storied building standing in some 13 acres of beautiful park-land. Fine staff quarters and animal houses are available. The climate is ideally suited to laboratory work and for the breeding of healthy animal stocks. In 1938-39 the Institute was completely renovated, re-furnished, re-equipped and re-organized as a model centre for the large-scale manufacture of anti-rabic vaccine, a first-class diagnostic laboratory and a research centre. The Institute possesses a good library and normally maintains a trained librarian.

In the earlier years of its existence, a considerable amount of research work was carried out by the Director and Assistant Director, both of whom were officers of the Bacteriological (now Medical Research) Department. The retrenchment of the post of Assistant Director and the increased volume of routine work curtailed the time available for research for some years. Active research activities were resumed in 1938 when a Research Officer was appointed as a regular Institute employee and an officer of the Medical Research Department was posted supernumerary to establishment. In addition, a grant of approximately Rs. 10,000 per annum was given by the Indian Research Fund Association for research on protozoal diseases (Protozoal Parasites Inquiry). In the following year an inquiry known as "Malaria Investigations" financed by the Rockefeller Foundation was located at the Institute. The Institute has also provided a home for the Nutrition Research Laboratories of the Indian Research Fund Association for many years. As the result of close co-operation between the various organizations and inquiries referred to above, the Institute was a very active research centre when war broke out in 1939. There followed a drastic reduction in the number of officers available for research and by 1941 research activities were again reduced to a low ebb. The renaissance lasted long enough, however, to demonstrate the suitability of the Institute as a centre for research.

## 2. *Tata Memorial Hospital, Bombay.*

65. This hospital maintains a series of well-designed and equipped research laboratories under the direction of a competent pathologist with long experience of research work. Although established only three years ago the laboratories are now adequately staffed with enthusiastic workers and it is evident that an active centre for medical research has been created. The laboratories are specially suited for research in biochemistry, biophysics, pathology

and clinical subjects especially surgical and radium therapy of cancer. The location of these laboratories in close proximity to other centres of research including the Haffkine Institute and the Seth G. S. Medical College is an additional advantage

### 3. *Indian Institute of Medical Research, Calcutta*

66. This Institute was founded by private enterprise through the initiative of its present Director, Dr. J. C. Ray. Its development has been retarded by lack of funds but the Government of Bengal has recently agreed to subsidize it to the extent of Rs. 10,000 per annum. Income is derived mainly from the sale of vaccines and other biological products manufactured at the Institute and from fees realized on diagnostic laboratory work carried out on behalf of private practitioners. Research has been a more or less spare time activity of honorary workers and has suffered greatly since the war. The Institute is located in a large residential apartment and is reasonably well equipped for the type of work undertaken. The Director edits a quarterly scientific journal, *Annals of Biochemistry and Experimental Medicine*, which has appeared regularly since 1941.

### 4. *The Indian Council of the British Empire Leprosy Relief Association*

67. The Indian Council of the British Empire Leprosy Relief Association was founded in 1925, a year after the Association was founded in London. Since then, branches of the Association under the Indian Council have been opened in most of the Provinces in India. The Indian Council and its provincial branches have stimulated interest in leprosy in this country and have undertaken research, the training of medical personnel and the organization of leprosy propaganda. The annual expenditure of the Indian Council is about Rs. 1,25,000. Of this sum more than half is distributed to provincial branches. The research work sponsored by the Council is carried out at the Calcutta School of Tropical Medicine in collaboration with work financed by the Indian Research Fund Association and by the Endowment Fund of the School of Tropical Medicine. Research activities have included clinical, therapeutic, bacteriological and epidemiological studies on leprosy. These investigations have increased the knowledge of this disease and have proved of value in the diagnosis, treatment and prevention of leprosy. Associated with this research work, special post-graduate courses have been held at the School of Tropical Medicine and hundreds of medical officers have already been trained in this way. In addition, lecture-demonstrations are given to the students attending the D.P.H., D.T.M., and L.T.M., courses of the School and the All-India Institute of Hygiene. The Council publishes a quarterly journal, *Leprosy in India*. In 1936, a Centre was established at Bankura for the investigation of the epidemiology of leprosy in rural areas. The results obtained in this Centre have yielded valuable information about the epidemiology of leprosy and have helped the evolution of a scheme for the control of leprosy in rural areas.

*5. The Indian Institute of Science, Bangalore*

68. The Indian Institute of Science, Bangalore, undertakes research work on the basic sciences on a large scale. The only department of this Institute at present engaged in research work which has a direct bearing on medical problems is the Department of Biochemistry. During the past four years, this department has concentrated on the study of biological products of therapeutic value and on methods for their preparation. For this purpose a pharmacologist, a pharmaceutical chemist and a bacteriologist were added to the staff of the department. Research has been carried out on the preparation of rennet, pepsin, pancreatin, insulin, pituitrin, adrenalin, vitamins and other preparations. Some of the products enumerated above have been prepared at the Institute and supplied to Government; in other cases the methods worked out have been handed over for development on a commercial scale by private enterprise. Recently, work on the cultivation of penicillium and the preparation of penicillin has been carried out. Other aspects of the research work of this department have included the study of sewage purification, sewage farming, the treatment of brackish water and the hygienic treatment of industrial liquid wastes. The research work carried out in this department tackles problems not adequately catered for in other laboratories in India and therefore promises to contribute results of practical value.

*6. The Imperial Agricultural Research Institute, New Delhi*

69. This Institute was established at New Delhi after the old Institute at Pusa had been badly damaged by the Bihar earthquake of 1935. The organization and layout of the Institute provide some valuable lessons, perhaps the most important of which are the necessity of allowing ample room for future development and the desirability of providing quarters for all members of the staff. The Institute is well organized and is provided with adequate accommodation, equipment and personnel for the type of work undertaken, which consists mainly of post-graduate teaching and research of an applied nature. The work of the Institute has little direct bearing on medical and health problems. Experiments have, however, been carried out on nutrition, chiefly in the Chemistry Section. For example, the nutritive value of wheat and maize crops raised on land manured with green manure, farm-yard manure and mineral manure has been determined by working out growth curves for rats. The results of these experiments indicate a higher nutritive value of wheat and maize raised on land treated with green manure, a slightly lower value for crops raised with farm-yard manure, and a definitely inferior value for crops raised with artificial manure. The Institute has also taken a keen interest in the cultivation of pyrethrum in India and it has now been established that high-grade pyrethrum containing up to 1.2 per cent. pyrethrines can be grown in the drier areas in India at elevations of 4,000-5,000 ft. in Kashmir, Muree, the Nilgiris and Mysore State. The work of the Institute, although having little direct bearing on medical problems, covers fields of investigation

sufficiently close to medical subjects to make it desirable to obtain a closer liaison between medical and agricultural research than has existed in the past. If the proposed new All-India Medical Institute were established, it is clear that the scientific work in the two research institutes could be of considerable mutual assistance in the solution of scientific problems. The very fine library available at the Institute would be an additional advantage to the new institution, wherever it be located.

The Director of the Institute considered that the climate of Delhi during the hot summer months was unsuitable for many types of work undertaken and stated that the quality and quantity of work done was very much greater during the cold season. He expressed the belief that if all buildings were air-conditioned the quality and quantity of work done during the summer months would be doubled.

#### *7. University College of Science, Calcutta*

70. The University College of Science, Calcutta, carries out research work of a very high standard in some of the basic sciences which have an important bearing on medical research, particularly on physics and chemistry. At the present time, the only work undertaken in this college, which is specifically related to medical problems, is the work on nutrition carried out under the direction of Professor B. C. Guha of the Department of Applied Chemistry, who receives a grant-in-aid from the Indian Research Fund Association for this purpose. The college is well staffed and equipped to undertake research in the basic sciences and it is felt that its work could, with advantage, be developed to be of great value to medical research in general, particularly in regard to the training of medical research workers in the basic sciences.

#### *8. Medical Research carried out by Commercial Firms*

71. There are in India to-day an increasing number of commercial concerns engaged in the production of pharmaceutical and biological preparations. Some of these are already firmly established and, as has been pointed out elsewhere, the standard of work of the better-known firms has now reached a much higher level than formerly. In some cases, special research laboratories are maintained, the workers in which undertake investigation in relation to the production of both pharmaceutical and biological preparations. Up to the present, most of these investigations have been directed to the practical production of these preparations but recently articles have been submitted for publication on subjects not directly related to commercial production. It is well known that some of the best known firms in America and Europe maintain their own research laboratories and that a great deal of scientific investigation of the highest quality has been carried out in them. It cannot be said that this stage has yet been reached in India but there are indications that the research activities of the scientific workers of the better known firms in India are likely to increase in the future. It may be presumed that some work of this type

will be regarded as a trade secret but it seems not unlikely that the results of work of general application may be freely published. Research work in commercial firms is to be encouraged as apart from the results achieved, the training and insight gained in its conduct are likely to lead to higher standards in relation to the commercial work undertaken.

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A. H. BUTT.

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H. R. WADHWANI.

K. C. K. E. RAJA, *Secretary.*

*New Delhi, 18th December, 1945.*

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**REPORT**  
**OF THE**  
**HEALTH SURVEY AND DEVELOPMENT**  
**COMMITTEE**

सत्यमेव जयते

**Vol. II**

**Recommendations**

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सत्यमेव जयते

# **REPORT OF THE HEALTH SURVEY AND DEVELOPMENT COMMITTEE**

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## **VOLUME II RECOMMENDATIONS**

### **CHAPTER I INTRODUCTION**

#### **The Health Problem in India**

1. A study of Volume I of our report cannot fail to reveal the extent and intensity of the dark shadows in the health picture of the country. It is not for us to apportion responsibility for the sombre realities which face us today. It is with the future that we are concerned and if the picture is to be substantially altered for the better with the least possible delay, a nation-wide interest must be aroused and the irresistible forces of an awakened public opinion arrayed in the war against disease. Only a vivid realisation of the grievous handicap which is today retarding the country's progress can help to mobilise an all-out effort in this campaign and infuse into it, a driving force which will gather and not lose momentum as time goes on. If it were possible to evaluate the loss, which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through mal-nutrition and preventible morbidity, we feel that the result would be so startling that the whole country would be aroused and would not rest until a radical change had been brought about.

We refer on page 35 of this part of our report to an estimate which has been made of the economic loss attributable to a single disease—malaria. Admitting that such assessments can lay no claim to mathematical exactitude, the figures, which come from an unquestionably authoritative source, even if approximately correct, are sufficiently arresting to demand something more than passing notice or academic interest.

2. We desire to avoid any semblance of special pleading in the emphasis we place on the paramount importance of health in any plan for the future development of the country. We realise that the most effective progress postulates a closely co-ordinated advance, in which complementary effort in many fields must be correlated, if the national development front is to move forward steadily, smoothly and with the greatest volume of practical achievement.

Nevertheless, we feel that a nation's health, using the term to signify that positive state of well-being in which mind and body are able to function to their fullest capacity, is perhaps the most potent single factor in determining the character and extent of its development and progress. Expenditure of money and effort on improving

the nation's health is a gilt-edged investment which will yield not deferred dividends to be collected years later, but immediate and steady returns in substantially increased productive capacity.

The worker, in whatever field he may be engaged, can only give of his best if his physical condition is not impaired by any disability resulting from the absence of sound health. We feel we can safely assert that a nation's wealth, prosperity and advancement, whether in the economic or the intellectual sphere, are conditioned by the state of its physical well-being.

In regarding national health as the foundation on which any plan of reconstruction must be based if it is to yield optimum results, we feel we are merely repeating an axiomatic proposition. We need no further justification for attempting to evolve a comprehensive plan which must inevitably cover a very wide field and necessarily entail large expenditure, if it is to take into account all the more important factors which go to the building up of a healthy, virile and dynamic people.

### **A Future Health Plan in Outline**

3. At the outset, we must ensure the conditions essential for healthful living in town and country-side. Suitable housing, sanitary surroundings and a safe drinking water supply are the primary conditions for securing such a measure of environmental hygiene as is essential to ensure the pre-requisites of a healthy life. Without these our towns and villages will continue to be factories of disease, which will help to maintain undiminished the demands on the curative side of the medical services.

The provision of effective means for the early detection and prevention of epidemic and communicable diseases must take a very high place in the organisation of public health measures, while improvement in nutritional standards must form an objective as fundamental as any in our basic plan of health development. Nutrition involves not merely a properly balanced but a quantitatively adequate diet, and this opens up avenues of enquiry beyond the scope of our task.

The elimination of unemployment, the provision of a living wage, improvement in agricultural and industrial production, the development of village roads and rural communications, as distinct from the great national highways now projected, are all so many facets of a single problem calling urgently for attention, though it lies outside our province to do more than make a passing but pointed reference to them. We should be failing in our duty if we omitted to stress the composite character of the problem with which we are faced and to point out that a frontal attack upon one sector alone can only end in disappointment and a waste of money and effort.

Nor can man live by bread alone. A vigorous and healthy community life, in its many aspects, must be suitably catered for. Recreation, mental and physical, plays a large part in building up the conditions favourable to sound individual and community health and must receive serious consideration.

4. Turning next to the problems more particularly concerned with the care of the individual, we must start at the very beginning. Every child has the right to be ensured a fair chance of living a normal, healthy life and of contributing eventually, as an adult man

or woman, its full share to the general advancement of the community. This will entail the proper care of expectant mothers and the provision of adequate ante-natal, natal and post-natal attention.

The child, during every stage of its journey towards adult life needs suitable care and attention. Its proper nutrition, its health care and health education, its physical development are matters of concern to the State, which must see that where parental efforts are inadequate, the child does not suffer. When the necessity arises for medical attention for the individual, there should be an adequate health service to turn to, from which no question of lack of means should cut him off. The ideal to be aimed at in a National Health Service cannot be more clearly described than in the words of the Ministry of Health in the United Kingdom in setting out its proposals for such a service. "The new service" it says "is designed to provide for every one, who wishes to use it, a full range of health care. No one will be compelled to use it. Those who prefer to make their own arrangements for medical attention must be free to do so. But to all who use the service, it must offer as and when required the care of a family doctor, the skill of a consultant, laboratory service, treatment in hospital, the advice and treatment available in specialised clinics (maternity and child welfare centres, tuberculosis dispensaries and the like), dental and ophthalmic treatment, drugs and surgical appliances, midwifery, home-nursing and all other services essential to health. Moreover, all these branches of medical care must be so planned and related to one another that every one who uses the new service is assured of ready access to whichever of its branches he or she needs". This is an ideal which we in this country may well place before ourselves, not as some distant shadowy objective to be approached through leisurely advances if and when conditions are favourable, but as a definite goal the attainment of which, at the earliest possible moment, is vital for the nation's progress and therefore demands an inflexible, concentrated and sustained effort on the part of all, to whom the nation's health and welfare are a matter of vital concern.

### **Impediments to Rapid Progress**

5. We realise, however, that there are serious impediments in the way of the early fruition of these hopes. The country's financial resources are limited. The trained personnel necessary to provide a health service of the expansive character we have in mind is unfortunately lacking at the moment, and this limitation is not one which can be removed today or tomorrow. It takes five years to produce a doctor and other key personnel require periods of training which, in many cases, must normally be measured in terms of years and not in months. Moreover social habits, customs, usages and existing standards of living may also call for modification, which in some cases may be profound, before the way can be effectively prepared and the requisite pre-conditions ensured for the proper functioning of the new health order which we envisage. Nor can the ideal of community health be achieved through a bottle of medicine or a surgical operation. It cannot be attained until the individual has learnt to realise that his neighbour's health is a matter of as much concern to himself as his own, that it is his own efforts which must help to decide the health pattern of the community circle in which he lives and that only a combined co-operative

endeavour on the part of all workers in the many fields of activity in that circle can yield results that are worth achieving. There is no magic wand to wave these changes into being overnight. The road to final achievement lies through purposeful endeavour, unrelenting toil and co-operative effort inspired by wise guidance and the light of a great ideal.

### **Long and Short Term Programmes**

6. Bearing in mind these limitations, we shall draw two pictures. One will depict a comprehensive health plan as we see it in the somewhat distant future, which we hope will give every man, woman and child a reasonable measure of protection against avoidable disease and suffering and adequate medical attention whenever this is needed. The other—a short-term plan—will present a programme indicating what we consider should be the minimum advance over the first two 5-year periods paying due regard to the restricting factors which must fetter our freedom of action and hinder the pace of progress.

In outlining this programme, we have tried to bear in mind the necessity for tempering enthusiasm with a sense of reality. In the earlier years the lack of sufficient trained staff and of adequate financial resources will inevitably limit the scope of practical achievement. With the initial impediments overcome or reduced, however, the pace of advance should be materially quickened. In Chapter III we give a general idea of what we regard as a suitable long-distance health objective to be placed before the country and reached in a period of years. We consider that it is inadvisable to attempt to plan now in meticulous detail for a term beyond the first two quinquennia. The advance of science, the progress of ideas, changes in circumstances and conditions may render out of date any detailed programme drawn up too far in advance. While, therefore, we feel it necessary to suggest, in some detail, a programme for the first two 5-year periods, we refrain from the same elaboration in respect of the later years. We shall, however, present in broad outline certain objectives, which should be kept in view during the third quinquennium.

### **Need for Periodical Review**

7. We would lay the utmost stress on the necessity for a periodical review of the position to take stock of what has been achieved and to make such changes in the plan as experience and the course of events may necessitate. The first review should in no circumstances be delayed more than five years from the date on which the plan is initiated.

### **The Needs of Rural India**

8. In these introductory observations we have tried to emphasise the importance of the health programme in any scheme of national planning and it appears to us to be of equal importance to place first things first in that programme. We have taken the countryside as the focal point of our main recommendations, for it is the tiller of the soil on whom the economic structure of the country eventually rests. It is his patient toil that year in, year out, gives the nation its food, such as it is, and the country's main manufacturing industries their raw material. It is from his meagre earnings that the larger provinces drew nearly a third of their total

## INTRODUCTION

revenues before the war. It is on the produce of his husbandry that the country's balance of foreign trade largely depends. When pestilence and famine sweep through the land it is he who pays the heaviest toll, while it is only the outermost fringe of such public services and amenities as the country enjoys that occasionally comes within the orbit of his daily life.

We need no further justification for making him the chief beneficiary under our proposals and if, in the initial stages, our recommendations appear to involve disproportionately heavy expenditure on teaching, training and ancillary institutions which, perforce, must be located in urban areas, it must be remembered that it is only when these are functioning effectively that we can hope to provide the means of doing a tardy measure of justice to the medical needs of the rural areas, where almost 90 per cent. of the population of the country lives and works and of repaying the cultivator a debt, which has long been overdue.

The essential aim of our proposals is to ensure the health of the masses of the people through the effective working of the centres we are recommending for rural areas.

### **Our Plan Subject to Local Modification**

9. We have no intention of attempting to draw up any rigid or unalterable blue-print for automatic adoption by the Provincial Governments in the country. We are merely suggesting a minimum target and ways and means of attaining it without unnecessary delay. We realise that local conditions, needs and circumstances may call for certain modifications in our suggestions. These, we venture to hope, will be possible within the broad outlines and the essential frame-work of our general plan.

### **Success Dependent on Co-operation of the People**

10. On one point, however, we desire to lay special emphasis. In our view, we shall be building on unstable foundations if we hope to secure any rapid or lasting improvement in health conditions without arousing the living interest and enlisting the practical co-operation of the people themselves. Unless they realise the benefits of the measures proposed and are prepared with vigour and persistence to help in giving them practical and effective shape, success must remain an elusive dream. While purely official effort may by itself not prove entirely sterile, it cannot possibly yield the results which we may reasonably hope to attain with the active, enthusiastic and enduring support of the people themselves.

## CHAPTER II

### MODERN TRENDS IN THE ORGANISATION OF A NATIONAL HEALTH SERVICE

#### Aims of a Progressive Health Service

1. A study of the tendencies apparent in some of the more progressive countries of the world in the development of organised health services for the community has been of great assistance to us in our consideration of the problems which lie before us, and a brief review of the general lines of development in such countries will, we believe, prove a helpful introduction to our recommendations. The modern trend in the provision of an organised health service for the community seems to be in the direction of ensuring that such a service satisfies the following requirements:—

- (i) that the service should be available to all citizens, irrespective of their ability to pay for it and
- (ii) that it should be a complete medical service, domiciliary and institutional, in which all the facilities required for the treatment and prevention of disease as well as for the promotion of positive health are provided. Thus there should be provision for every patient, if his condition requires it, to secure the consultant, laboratory and other special services which may be necessary for diagnosis and treatment. There should also be provision for the periodical medical examination of every person, sick or healthy, so as to ensure that his physical condition is appraised from time to time and that suitable advice and medical aid, wherever necessary, are given in order to enable him to maintain his health at the highest possible level.

#### Preventive and Curative Health Services

2. The health services may broadly be divided into (i) those which may collectively be termed public health activities and (ii) those which are concerned with the diagnosis and treatment of disease in general. As regards the former, which are directed towards the creation of conditions favourable to healthful living and which embrace many fields in which State action is essential for the provision of the required facilities and the enforcement of legal measures, the responsibility in all countries rests on the public authority. Public health activity, in the early stages, was confined mainly to environmental hygiene but it began to embrace, later, various forms of personal services particularly in relation to mothers and children, the school-going population and to patients suffering from infectious diseases, such as tuberculosis and venereal diseases. These developments brought in their train the need for providing adequate facilities for the diagnosis and treatment of disease in relation to these sections of the population as an essential part of the public health programme.

Turning to (ii), viz., organised medical services for the diagnosis and treatment of disease, the practice varies considerably. There exist varying combinations of State and private medical services for the people. For instance, it is understood that most of the hospitals



in Denmark are maintained by public authorities, while in Canada there exists a system of public doctors maintained by municipalities on the basis of a salary or a schedule of fees paid to them by these local authorities. Side by side with the facilities for medical relief for the community provided by the State, relief is also available through private practitioners, medical institutions maintained by voluntary societies and through health insurance schemes on a voluntary or State-aided basis covering limited sections of the population. Even where the bulk of the medical service for the community is given by private practitioners, the need for consultant and laboratory services has been recognised and the development of voluntary "group" practice by doctors or the provision of such facilities by insurance or other organisations providing medical services has become a noticeable feature.

The ferment of ideas arising out of the World War has resulted in an increasing awareness, on the part of Governments and peoples, of the need for measures which will ensure social security, and health protection is becoming recognised as an essential part of social security. The idea that the State should assume full responsibility for all measures, curative and preventive, which are necessary for safeguarding the health of the nation, is developing as a logical sequence.

### **Social Medicine**

3. In interpreting health and disease man must be considered in relation to his social and physical environment. The study of disease as a community problem demands that the approach should be on a wide basis so as to include social and economic factors such as housing, nutrition, poverty and ignorance of the hygienic mode of life. The causative organism of tuberculosis, for instance, is widely spread in highly industrialised and urbanised communities and yet the incidence of the disease shows a remarkable variation, depending largely on variations in social and economic conditions. The remedial and preventive measures that are adopted in respect of individual patients will largely fail to achieve results, if these factors are not considered and if the necessary steps are not taken to neutralise their harmful effects. A recognition of these facts has led to the emergence of "Social Medicine", which has widened the conception of disease from the narrow view of tissue changes and microbial and other specific causes by the inclusion of social, economic and environmental factors which play an equally important part in the production of sickness. In consequence, social medicine is beginning to develop its own methods of study of the community health problem. In the words of Professor John A. Ryle, "the socio-medical survey, that is to say, the combined social and clinical study of community health and sickness, often with special nutritional and economic assessments and careful sampling and controls", is coming to be accepted as the correct method of approach to such study. Side by side with such surveys controlled experiments directed towards influencing the life of selected communities through the provision of improved health services, better nutrition, a cleaner environment and health education have become recognised as a valuable method of extending experimental practice in the laboratory into the field of community life. This wider outlook has brought into the sphere of social medicine many workers besides the doctor.

They include the public health nurse, the hospital social worker, the nutritionist, the public health engineer and the statistician.

### **Development of National Medical Services in different Countries**

4. The latest developments in the organisation of national medical services in a few countries may now be briefly described.

(a) *Great Britain*.—The scheme for a national health service outlined in the White Paper issued by His Majesty's Government in Great Britain is intended to provide a comprehensive health service to all. Some idea of the degree of comprehensiveness that has been envisaged may be obtained from the following quotation from the White Paper:—

“It must cover the whole field of medical advice and attention, at home, in the consulting room, in the hospital or the sanatorium, or wherever else is appropriate—from the personal or family doctor to the specialists and consultants of all kinds, from the care of minor ailments to the care of major diseases and disabilities. It must include ancillary services of nursing, of midwifery and of the other things which ought to go with medical care. It must secure first that everyone can be sure of a general medical adviser to consult as and when the need arises, and then that everyone can get access—beyond the general medical adviser—to more specialised branches of medicine or surgery.”

It is stated that, under the scheme, individual members of the public “will be able to obtain medical advice and treatment of every kind entirely without charge except for the cost of certain appliances. They will be paying for medical care in a new way, not by private fee but partly by an insurance contribution under whatever insurance scheme is in operation and partly by the ordinary process of central and local taxation.” The respective shares of the total cost of the scheme which will fall on the social insurance organisation, the taxpayer and the ratepayer are 27, 36·6 and 36·4 per cent.

(b) *The Commonwealth of Australia*.—The proposals for the re-organisation of medical services in that country embody principles which are indicated in the following quotation from a recent memorandum issued by the Minister of Health, which is entitled “The Health Policy of the Australian Government”: —

“For the people are necessary:—

The knowledge that they may, as their right, require from the Government such medical and hospital services as they really need without the humiliation of proving their financial status, or the bitterness of accepting charity.

The knowledge that the breadwinner will not have to face a crippling bill for hospital and medical services if he, or any member of his family, suffers a prolonged illness.

It is intended, although this stage has not yet been reached, that every person shall have the right to receive medical advice from a doctor whenever he is ill and without any cost to himself. This will apply in the case of

every Australian citizen, including women and children, and will not be limited by any consideration of the financial status of the patient."

As far as is known, the present position is that a scheme proposed by the National Health and Medical Research Council is under consideration by the Commonwealth Government which, it is understood, has been or is likely to be entrusted, in the near future, by the several State Parliaments with the control of national health in co-operation with the States. This scheme proposes a national salaried medical service based on a system of health centres throughout the populated area of the Commonwealth which will be divided into health districts. These would, as far as possible, be also hospital districts in order to co-ordinate the preventive and curative health functions. The scheme will be financed by direct taxation and the co-ordination of the services will be on a Commonwealth-wide basis.

It has been stated that the scheme, whatever form it may eventually take, will be introduced only after the War.

(c) *The United States of America.*—Careful investigations carried out in America have revealed that adequate medical care is very costly for large sections of the population of that country and that, in many areas, the poorer sections of the community lack suitable medical facilities. There exists no State insurance scheme in the country.

Two developments are said to be in progress for the provision of an adequate medical service:—

(1) The Federal Government proposes to assist States, through subsidies, to expand hospital and other forms of health service, particularly in those parts of the country where they are most needed.

(2) A second development of great importance is the promotion of "co-operative medicine", a form of private medical insurance which guarantees adequate service during times of sickness through the payment of small premia. As a rule the doctors employed in this system are full-time salaried officers and specialist and laboratory services are also associated with it.

An outstanding example of such insurance medical services is the health plan evolved under the inspiration of Henry Kaiser, the ship-builder, and the technical guidance of Dr. Sidney R. Garfield, in the shipbuilding area on the Pacific seaboard of the United States of America in California and Washington States. Through a system of weekly payments complete medical cover has been provided for the worker and all the members of his family.

(d) *Canada.*—The Canadian approach towards the improvement of the national health is embodied in the draft Bill which empowers the Federal Government to give grants to Provinces in respect of approved health insurance schemes and public health services. The Bill contains three schedules, the first of which gives a list of the grants and the conditions governing them, the second consists of a draft model Health Insurance Bill for adoption by the Provinces and the third lists the different types of health services that are to be maintained. The grants include a health insurance grant, a

general public health grant and special grants for work in respect of tuberculosis, mental diseases, venereal diseases, professional training, public health research and crippled children.

The draft Bill provides that no province can qualify itself for grants unless such Province has made statutory provision for utilizing both the health insurance grant and the general public health grant. It will thus be seen that financial aid from the Centre is dependent on the introduction of the health insurance scheme by the provinces. Every adult (16 years and over) must contribute to the scheme if self-supporting and, if not, the person on whom he is dependent must pay a specified amount.

The Canadian Government definitely prefers a contributory social insurance scheme to a health service financed entirely out of public funds. The Minister of Pensions and National Health gave the following reasons for this:—

“A completely free or non-contributory system may encourage the pauper mentality, may lead to a delusion that the public purse is bottomless”. He pointed out that it is “more consistent with the dignity and independence of a man that he shall be enabled to apply for something that he has purchased with his own funds. Under a contributory system, benefit becomes a right and not a concession”. He also said that individual beneficiaries “are kept in touch by their contributions with the actual cost of the services they receive”. An improvement in the health of the community will be reflected in a reduction of the contributions while abuse of the system will lead to an increase in contributions. Thus a contributory system should help to secure the co-operation of all the beneficiaries in eliminating abuse as far as possible.

(e) *The Union of Soviet Socialist Republics.*—The attitude of the Soviet Government towards the health of the people has been described by Professor Sigerist in the following words:—

“Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health accessible to all, free of charge; medicine like education is then no longer a trade, it becomes a public function of the State.”

This conception of health as a public function has resulted in the development of a co-ordinated scheme of preventive and curative health services, which exists in no other country, and in the recognition of the need for providing an environment which will enable the body to remain healthy and to resist disease. “For this reason the control of housing, of industrial conditions, and other aspects of life, comes under the care of the People’s Commissariat of Public Health. Another function of that department is to encourage and look after the communal restaurants which, in the Soviet Union, have achieved such popularity that they serve 20 million people a day”.\*

The health service is entirely free to the people and places at the disposal of the patient not only the services of the general practitioner but also of the specialist as well as laboratory facilities.

\* “Health for All” by Stark Murray.

The following quotation from "Health for All" by Stark Murray throws light on the structure and functions of the Russian health services:—

"The structure of the Soviet medical system follows the general administrative structure of the country. In order that planning may be complete for the whole State it is controlled on the one hand by the People's Commissariat of Health, on the other hand by health committees and health nuclei organised in every factory, on every one of the large collective farms, and in every district. The one form of control is the natural outcome of the recognition that health protection is a function of the State, the other is the logical outcome of the principle that the workers themselves must take an active part in the protection of their own health. The system as it now stands is therefore not one forced on either the people of Russia or the medical profession by a particular group or class, but has had the active support and criticism of those interested in the service either as the purveyors of medical treatment or as the consumers of medical care.

"It will be recollected that Russia takes her present name—the Union of Socialist Soviet Republics—because the administration is divided up so that local government is carried out by a form of local authorities known as Soviets. Under the constitution, each of these Soviets appoints certain committees for certain functions and one of these must always be concerned with the public health. Its duties, as laid down by a decree on January 1st, 1931, are:—

- (a) to supervise all hospitals and sanitary establishments;
- (b) to take all necessary steps in the organisation of sanitary inspection and combating venereal disease;
- (c) to advance the knowledge of personal hygiene and develop physical culture.

In addition it has other duties in relation to social insurance.

"There are altogether some seventy thousand such Soviets in Russia, apart from the Soviets of the larger cities which function in a slightly different way, not without parallel in the case of an urban district council and a borough council in one of the large cities of this country. The smaller Soviets are linked in districts or Rayons, and each of these has an Inspector of Public Health, a doctor, who is responsible for the entire health work of the district. A large city such as Moscow, which has its own central Soviets and local Soviets, is also divided into districts comparable to the boroughs of London, and each of these also has its own health department and its own Inspector of Public Health. In the very largest districts further subdivisions may be made, for it is the aim of the system to use units which can reflect the needs of the individual citizen.

"The districts or Rayons are further centralised in larger units which we may call regions, and these are in turn under the central administration of each of the Republics through a Commissariat of Public Health. This Commissariat directs and controls the whole of the health work of the Republic, and is concerned therefore with the prevention, diagnosis and cure of disease. In addition it controls medical education, medical research, and any industries connected with medicine. It should also be noted that while the local health departments are responsible to the general executive committee in administrative and financial matters, their responsibility in regard to medical and sanitary problems lies entirely with the Commissariat of Public Health: there is, therefore, no interference with purely medical questions by organisations or authorities not directly connected with the medical profession. As a further safeguard it is laid down that the Commissar of Public Health must be medically qualified."

(f) *New Zealand*.—In New Zealand there is a Social Security Act which provides, among other things, a free and complete medical service to the whole population. The service was designed to operate like the panel system in Great Britain, the doctors working in their individual capacity and payment being made to them on a capitation basis. Well-to-do individuals are not compelled to accept free treatment, but they are entitled instead to a cash payment, which can be utilized by them towards defraying the cost of the treatment or hospital care when obtained from a private physician or hospital.

It is understood that the medical profession, as represented by the British Medical Association in New Zealand, refused to operate the scheme and that the Government, therefore, had to agree that, when a doctor refused direct payment from the State, patients could continue to pay the doctor as before and recover such payments from the State.

### **Summary of Modern Trends**

5. To sum up, the modern trend is towards the provision by the State of as complete a health service as possible and the inclusion, within its scope, of the largest possible proportion of the community. The need for ensuring the distribution of medical benefits to all, irrespective of their ability to pay, has also received recognition. Provision of medical relief for the community has developed, in the past, on a contractual basis between the doctor and his patient. The latter has had the right of choosing his own doctor and in countries, where the family physician system has been in existence, the knowledge of the doctor in respect of individual members of the family and the regard and esteem of the latter towards the doctor have been of advantage to both parties. Further, individualism in medical practice has promoted wide opportunities for those practitioners who are successful in their professional career, and has provided the incentive for ambitious and capable men to make the most of their talents. To them a change-over from independent medical practice to a salaried State service is naturally repugnant. Apart from these, there are certain sections of the medical profession which view with genuine apprehension the results of making over the function of

providing medical protection for the community entirely to the State. They fear that political influence or considerations of seniority or administrative ability may play an undue part in influencing promotion. They also fear that the security of tenure and graded scales of salary that a State service will provide, might discourage initiative and the pursuit of efficiency. There is, in addition, the feeling that the free choice of a doctor by the patient and the intimate relationship, which the family doctor system has helped to develop in the past, might also be disturbed. We do not feel called upon to pursue controversies in regard to this question because, as we shall show later, our conditions are such as to leave no option in the matter. We are satisfied that our requirements can only be met satisfactorily by the development and maintenance of a State health service.

### **The Application of these Trends to India**

6. We may now ask ourselves the question how far these modern trends in other countries are applicable to India. While inadequacy of trained personnel and of funds may set limits to the rate of progress in the expansion of the health services in the country as a whole, the enunciation of certain definite principles on which such expansion should be based is of great importance. The following questions seem, at the outset, to require an answer:—

- (1) Whether the service should be free or paid for by the recipient; if the latter, whether it should be a graded scale of payment so as to suit the level of the patient's income; and whether such payment should be made on each occasion when service is rendered or through some form of sickness insurance;
- (2) Whether our scheme should be based on a full-time salaried service of doctors or on private practitioners resident in each local area or settled there on a subsidy basis;
- (3) Whether, in either case, some measure of choice can be given to the patient as regards his doctor.

(1) *Whether the medical service should be free or whether it should be paid for.*—The general tendency appears to be towards basing the national health plan on a system of social insurance. One reason for this may be found in the view expressed by the Australian Minister of Health that the people should be spared the humiliation and bitterness of accepting charity. The same view has been taken by the Canadian Government which has based its health programme on a compulsory system of social insurance. In Great Britain the proposed national health service will be financed "partly by an insurance contribution, under whatever insurance scheme is in operation, and partly by the ordinary process of central and local taxation." In the United States of America, no national scheme for the promotion of health is, at present, in operation. A system of "co-operative medicine" which guarantees adequate medical service to the employees during times of sickness through the prepayment of small amounts is becoming a growing feature of industrial life. But this system depends largely upon the private employer and is not a State enterprise. Even in Soviet Russia, where medical care is free to all, the cost of the services is partly met from insurance funds. Contributions towards these funds are, however, not made

by the individual workers but by the factories and other institutions in which they work.

In India it is recognised that there are difficulties in the way of introducing, at present, a scheme of health insurance either by itself or as part of a universal social insurance scheme. We feel that a very large section of the people are living below the normal subsistence level and cannot afford as yet even the small contribution that an insurance scheme will require. We therefore consider that medical benefits will have, in any case, to be supplied free to this section of the population until at least its economic condition is materially improved. We are averse to drawing any line of distinction between sections of the community which are and are not in a position to pay for such benefits. The application of a "means test" for this purpose is unsatisfactory and may often involve inquisitorial enquiries. Such enquiries place an unpleasant duty on the officer making them and may give rise to resentment and a sense of grievance. We consider, therefore, that for the present medical service should be free to all without distinction and that the contribution from those who can afford to pay should be through the channel of general and local taxation.

It will be for the Governments of the future to decide ultimately whether medical service should remain free to all classes of the people or whether an insurance scheme would be more in accordance with the economic, social and political requirements of the country at the time.

We should like to record the following general recommendations regarding the provision of health service to the community in the near future:—

- (i) that public funds should, as far as they are available, be devoted to the development of the health service, which we have recommended, for the community in general and for certain particular sections of it, e.g., women and children and should not be spent on the provision of special facilities for other sections of the population.
- (ii) that the money for such special facilities, if they are to be developed, should be provided by the communities or groups which will be benefited by these services and
- (iii) that the general health service should minister to the needs of the people without charge to the individual.

These recommendations are subject to the explanation which we have given on page 126 in the chapter dealing with industrial health.

(2) *A salaried service as against a service of private practitioners.*—One of the fundamental requirements in developing an adequate health service for India is the provision of the requisite health personnel to cater to the needs of the large rural population in the country. This is a question which has presented very considerable difficulty in the past. The absence of certain amenities and services in the countryside has proved a deterrent to medical practitioners leaving the attraction of cities and towns and migrating to the villages. Various attempts have been made to solve the problem. One method, which has been tried in more than one province, has been the settling of medical practitioners in rural areas and giving them a subsidy which will enable them to start practice.



This subsidy was intended to be supplemented by private practice among the richer sections of the community. We have had considerable evidence to show that this method has been far from being an unqualified success, partly because in many villages the income derived from private practice is too small to support the doctor in reasonable comfort. The result has been that, in many cases, the better type of such subsidised doctors has tended to gravitate back to the towns. In areas where there are greater opportunities for private practice, the more prosperous sections of the community have, we were told, generally received greater attention than the poor. We have, therefore, come to the conclusion that the most satisfactory method of solving this problem would be to provide a whole-time salaried service which will enable Governments to ensure that doctors will be made available where their services are needed. The evidence tendered before the Committee by a number of representatives of medical associations, by private individuals and by several responsible medical administrators lends strong support to this proposal.

(a) *Prohibition of private practice by whole-time salaried doctors.*—The next question is whether these whole-time salaried doctors should be permitted private practice or not. Our view is that, at the periphery, the same doctor should combine curative and preventive functions and that the training of the future doctor should be modified so as to enable him to carry out these composite duties. In so far as preventive health work is concerned, the practice everywhere is to give the medical officer responsible for it adequate emoluments and to prohibit private practice. As regards medical relief the practice has so far been to permit private practice, but the desirability of doing so in the future requires serious consideration. There was a general agreement, among those whom we interviewed, that prohibition of private practice was essential in order to ensure that the poor man in the rural areas received equal attention with his richer neighbour. Many of the smaller towns do not differ materially from rural areas and the remarks in the preceding paragraphs apply equally to them.

Further, the fact that curative and preventive functions will, under our proposals, be combined in the same individual also seems to require the prohibition of private practice. Otherwise it is almost certain that a doctor's preventive duties will not receive the attention which is essential.

(b) *Part-time medical men.*—In some of the larger district headquarters towns and particularly in the cities, the number of general practitioners with high qualifications and of specialists has been growing during recent years. The possibility of utilising their part-time services to supplement the health organisation in these urban areas may with advantage be considered, particularly in the transition period before the programme of professional training recommended by us provides the country with an adequate number of trained men and women for the different branches of the health service.

Even in our long term proposals outlined in the next chapter we have suggested the inclusion of a certain number of part-time medical officers to be employed in the hospitals at the headquarters of secondary units and of districts. We have suggested that their proportion to the total strength of medical officers at the two types:

of hospitals might be about 25 per cent. The reason for the inclusion of part-time workers in these hospitals will be explained in the next chapter.

(c) *Employment of doctors on an honorary basis.*—The question of the employment of doctors on an honorary basis also requires careful consideration. As regards the long-term programme, our proposals for an expanding health organisation will probably lead to the absorption into the public service of the large majority of existing doctors as well as of those who will be trained in the future. Further, if these services prove efficient and satisfactory for meeting the needs of the people, it may be expected that the scope of activity for practitioners who, by choice, remain outside the State health services, will become limited to a section of the community consisting almost entirely of its wealthier members. Those who cater to the medical needs of this section will probably be few in number. They are, however, likely to be of a high standard of professional skill and academic attainments and it is possible that it may be found advantageous to make use of their services in an honorary capacity.

During the first ten years the need for medical men will undoubtedly be great and there seems, therefore, every reason for utilising the services of those who are prepared to work on an honorary basis. At the same time, the employment of professional men in a paid part-time capacity is normally to be preferred to honorary service. The State would, in this case, acquire greater powers of supervision and control over a worker than if he gave his services free of charge.

(d) *A salaried State health service no serious impediment to private practitioners.*—We consider that any apprehension that private practitioners will be seriously affected to their detriment by our proposals for a State health service is unfounded. In the first place, the need for doctors to man the services we contemplate will be so great that we believe that all existing private practitioners, who desire to enter these services, will be able to do so if they fulfil the requirements that may be laid down. We feel that age should not, of itself, be a bar to such entry provided the applicant is fully qualified otherwise to fulfil the duties to be assigned to him. Those who prefer to remain in private practice will, we believe, not find their opportunities seriously circumscribed. It will be long before the entire population can be served by our proposed health services and our plan also provides for the utilisation of private practitioners in a part-time and honorary capacity.

(3) *Freedom of choice of a doctor.*—Such freedom will only be restricted by practical considerations. We contemplate that it will be open to any patient to obtain treatment free at any State institution in the country. This will afford a wide choice of doctors though we realise that in practice it may not be possible for an individual patient to go for treatment far from his home. In the later stages of our plan when a larger number of institutions will be opened, the choice available to the residents in a particular locality will naturally be widened.

## CHAPTER III

### HEALTH SERVICES FOR THE PEOPLE

#### The Long-Term Programme

##### A Well Developed Health Service

1. In formulating plans for a national health service it is desirable to keep in view the objectives that are to be achieved. These include the following:—

- (1) the services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health;
- (2) these services should be placed as close to the people as possible, in order to ensure their maximum use by the community which they are meant to serve;
- (3) the health organisation should provide for the widest possible basis of co-operation between the health personnel and the people;
- (4) in order to promote the development of the health programme on sound lines the support of the medical and ancillary professions, such as those of dentists, pharmacists and nurses, is essential; provision should, therefore, be made for enabling the representatives of these professions to influence the health policy of the country;
- (5) in view of the complexity of modern medical practice, from the standpoint of diagnosis and treatment, consultant, laboratory and institutional facilities of a varied character, which together constitute "group" practice, should be made available;
- (6) special provision will be required for certain sections of the population, *e.g.*, mothers, children, the mentally deficient etc.;
- (7) no individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it and
- (8) the creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation, are essential.

2. It may not be out of place to offer here a few remarks on some of the requirements of a national health service which have been enumerated above. The old adage that prevention is better than cure has acquired added significance as the result of the great achievements of modern preventive medicine, which has reduced in many directions unnecessary suffering and mortality and has helped to lengthen life. A sequel to this preventive campaign, which was at first directed mainly towards the control of infectious diseases and has later included, within its scope, other causes of mortality such as cancer and diseases of the circulatory system, has been the recognition of the need for promoting measures designed not only to prevent disease but also to develop a sense of well-being in the individual and

his capacity to enjoy work and life to the fullest possible extent. Adequate nutrition, physical culture, recreational facilities, particularly those promoting co-operative effort and the team spirit, and health education directed to the inculcation of the principles of hygienic living have, therefore, become recognised as integral parts of a modern health campaign.

3. Preventive and curative health work must be dovetailed into each other if the maximum results are to be obtained and it seems desirable, therefore, that our scheme should provide for combining the two functions in the same doctor in the primary units, rural and urban, where the health organisation will be in close touch with the population.

4. The closer the health service can be brought into contact with the people whom it serves the fuller will be the benefit it can confer on the community. The scheme must therefore provide for the creation of a large number of units, each including within itself only such proportion of the population as can be catered for adequately by the health staff that will be employed. These units will naturally be able to offer service of only a limited nature. They must, therefore, be supported by a series of appropriate organisations in an ascending scale of technical efficiency in order to secure for the people all the benefits of modern health practice.

5. The need for the fullest co-operation between the health personnel and the people whom they serve requires special emphasis. Such co-operation is essential in order that the health campaign may produce its full effect on the individual and on the community. The patient possesses, as a living being, an organic unity based on established habits and these determine largely the extent to which he responds to the medical care bestowed on him. The eradication of undesirable habits can follow only through his co-operation. As regards the community many problems of environmental hygiene, the solution of which is fundamental to the prevention of disease, can be solved only with the help of the people. It is therefore considered that the ideal to be aimed at in the development of the community's health organisation is its evolution as a joint effort in which the leaders of thought in the medical world and among the people fully participate. The physician of tomorrow, who will naturally be concerned with the promotion of the new era of social medicine, has been well described by Professor Henry F. Sigerist in the following words :—

“Scientist and social worker, ready to co-operate in teamwork, in close touch with the people he disinterestedly serves. a friend and leader he directs all his efforts towards the prevention of disease and becomes a therapist where prevention has broken down, the social physician protecting the people and guiding them to a healthier and happier life.”

6. A health organisation enriched by the spirit of such a medical profession will naturally work towards the promotion of the closest co-operation with the people. It will recognise that an informed public opinion is the only foundation on which the superstructure of national health can safely be built. The people, in their turn, will hasten the pace of progress by demanding increasingly higher standards of service, by requiring the authorities to devote to the development of

the health programme all the money that can be made available and by promoting, through their active co-operation in the health programme, the attainment of a progressively higher standard of individual and community health.

It is also necessary that the structure of the health organisation should be such as to enable the people to influence, through their representatives, the health policy of the country at the three levels of Central, Provincial and Local-Body Administration. Machinery will also be required for associating the medical and ancillary professions with the progressive development of the health programme.

### **Central, Provincial and Local Area Health Organisations**

7. Our proposals deal with the structure and functions of the health organisations that are to be associated with the Central and Provincial Governments and with local authorities in the districts as well as with the inter-relationships of these different types of health administrations. The implementation of these proposals presents two major difficulties, namely, inadequacy of trained health personnel and lack of funds. The process of expansion will, therefore, be necessarily slow, particularly in respect of the district organisations, which will require the largest share of the money and staff involved in the development of the scheme. At the same time the directional organisations associated with the Central and Provincial Governments, which will be concerned with the execution of the development programme, will have to be provided at a much earlier stage in order to furnish the machinery necessary to initiate action.

8. In view of what has been stated above we feel that, in setting forth our proposals, it will make for clarity if the major objectives of a fully developed programme to be attained in thirty or forty years and the smaller scheme for implementation within the first ten years are dealt with separately. The organisations at the headquarters of the Central and Provincial Governments form integral parts of the long and short-term schemes. A description of these organisations is therefore necessary to complete the picture in each case. Nevertheless, a full consideration of the proposals for these Central and Provincial headquarter organisations will have to include, within its scope, various matters relating to the formulation and administration of health policy and the mass of details that may be brought into the discussion is more likely to blur the picture than to add to its clearness. It is therefore proposed that, in the succeeding paragraphs of this chapter, the long-term programme should be set out with only such a brief reference to the organisations at the headquarters of the Central and Provincial Governments as may be necessary to ensure that the scheme can be perceived as an integrated whole. In the next chapter (Chapter IV) will be discussed the short-term programme, which will provide a more attenuated form of health organisation for limited areas and will, at the same time, constitute an arduous stage of preparation for the development of the fuller type of health organisation proposed for the succeeding stages of the scheme. Chapter XVII will be devoted to a detailed discussion of the health organisation, as a whole, which will bring under review the principles underlying our proposals and the inter-relationships between the Central, Provincial and Local area health administrations.

9. We consider it fundamental that the development of the future health programme should be entrusted to Ministries of Health at the

Centre and in the Provinces, which will be responsible to the people and sensitive to public opinion. The need for developing the programme in the closest possible co-operation with the people has already been stressed. Both in respect of legislation and of administration it is likely that some of the measures to be undertaken may offend existing social and religious practices, while others may involve control over the day to day life of the citizen. We therefore feel that it is only a Minister, enjoying the confidence of the people, who can carry such enactments through the legislature and ensure their practical application in the country.

10. The Portfolio of Health at the Centre and in the Provinces should be in charge of a separate Minister. At present various other subjects, such as education or local self-government, are part of the functions of the Ministers in charge of Health. The task of developing the health programme is of such magnitude that a separate Minister for this subject alone appears essential.

11. We have given careful consideration to the question of the existing distribution of health functions between the Centre and the Provinces and to the large measure of autonomy that has been granted to the latter under the Government of India Act of 1935. For reasons which will be fully discussed in Chapter XVII, we have come to the conclusion that certain principles should be taken into consideration in formulating plans for future development. These are:—

- (1) It is desirable that the wide measure of autonomy, that has been granted to the Provinces, should be respected to the largest possible extent. At the same time our proposals for the future will involve considerable changes in existing health administration and professional education and we therefore feel that, in carrying out these recommendations, the closest possible co-operation between the Centre and the Provinces will be essential. In order to minimise the possibility of friction, to promote mutual consultation and secure co-ordination between the Centre and the Provinces in the formulation of health policy and its implementation, there should be established a Central Statutory Board of Health consisting of representatives of the Central and Provincial Governments. We also assume that the Centre will continue to be in a position to assist the Provinces with grants-in-aid and advice in the development of their health programmes. One of the important functions of this Board should be to make recommendations to the Central Government regarding the distribution of grants-in-aid.

In our view the co-operation that may be expected to develop, as the result of these proposals, between the Central and Provincial Governments, should help to establish a firmer foundation for the harmonious development of the health programme over the country as a whole than any resumption of powers by the Centre. It is recognised that there will be certain exceptional circumstances in which the Central Government should have power to

intervene in Provincial administration in the interests of the remaining parts of the country. This question has been dealt with more fully in Chapter XVII. It is, however, to be expected that the machinery for consultation and co-operation which has been suggested



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tration and it is therefore essential that they should function in close association. This is particularly desirable because we consider that no reasonably rapid advance in the public health of a country can be achieved without a simultaneous advance in other fields of activity such as education, agriculture and animal husbandry, industry, irrigation and communications. The district health organisation will be under the control of an officer responsible for both curative and preventive health functions in the area. In order to afford local public opinion the fullest opportunity for influencing the health policy the creation of a District Health Board consisting of representatives of the urban and rural health authorities in the district and the District Collector as members is suggested, while a District Health Council consisting of experts will provide the technical advice and guidance that the Board may require in the promotion of its health programme.

With this brief description of the proposed controlling organisations at the Centre, in the Provinces and in Districts, we may now turn to the presentation of the detailed plan which we have in mind.

### **The District Health Organisation**

12. Two requirements of the district health scheme are that the peripheral units of the organisation should be brought as close to the people as possible and that the service rendered should be sufficiently comprehensive to satisfy modern standards of health administration. It is recognised that districts vary from province to province and within individual provinces, to such an extent in respect of population and area as to make any standards we may suggest only a pattern on which Provincial Governments can base their own organisations to suit local conditions. The recommendations set forth in the following paragraphs should be considered in the light of these remarks.

13. The district health scheme will consist of three types of organisation in an ascending scale of efficiency from the point of view of staffing and equipment. At the periphery will be the primary unit, the smallest of these three types. A certain number of these primary units will be brought under a secondary unit, which will perform the dual function of providing a more efficient type of health service at its headquarters and of supervising the work of these primary units. The headquarters of the district will be provided with an organisation which will include, within its scope, all the facilities that are necessary for modern medical practice as well as the supervisory staff who will be responsible for the health administration of the district in its various specialised types of service.

14. A district in British India is divided, for administrative purposes, into a number of subdivisions and each of the latter is further divided into smaller units which are known as 'thanas' in north-eastern India, as 'tehsils' in the remaining provinces of northern India and in the Central Provinces and Berar and as 'taluks' in the provinces of Madras, Bombay and Sind. A taluk or a tehsil is larger than a thana, the average population of which varies in the three provinces of Bengal, Assam and Bihar from about 78,000 to 181,000. The average area of a thana ranges from about 127 to 420 square miles [see appendix (1)]. In order to ensure that adequate health



service is given to the people, there should be much smaller units of health administration. In fixing the standard for such a unit the population to be included and the area to be covered should both be taken into account. The extent to which communications have been developed in the area concerned will also have a bearing on the question. But we have assumed that, as the result of a simultaneous advance of the development programme in respect of communications, the large differences in this respect that now exist between various parts of the country will have been removed to a considerable extent by the time the long-term programme under discussion is reached. It is recommended that the population covered by each primary unit should be in the neighbourhood of ten to twenty thousand. A wide range of population has been suggested because of the varying concentration of population in the different provinces. In Bengal with its high density per square mile, a population of 20,000 covers on an average 25.6 square miles. On the other hand, in Sind the much smaller figure of 10,000 is distributed, on an average, over 106.1 square miles. Even within individual provinces the variations in density are considerable so that it seems likely that different standards will have to be adopted for primary units in different parts of the same province. Provincial Governments alone seem to be competent, in the light of local circumstances, to determine what the size of the unit should be. A population of 10,000 to 20,000 is suggested as probably being suitable over most parts of the country.

15. The area covered by each subdivision should be divided into primary units on the lines suggested above, with a secondary unit at the subdivisional headquarters. As has already been suggested, the organisation at the headquarters of the district will supervise, co-ordinate and regulate the health activities throughout the district.

### **The Three Million Plan**

16. The wide variations that exist, between provinces and within provinces, in the area and population of individual districts have necessitated, in the presentation of our scheme, the drawing up of a plan which is based on an arbitrarily chosen unit of population. A figure of three millions has been taken to represent a district and, in the description that follows and in the report generally, the plan will therefore be referred to as the three-million scheme. In carrying out these proposals the details which have been given regarding the strength of personnel and cost will have to be modified in the provinces so as to suit the size and population of their individual districts. The need for adopting the administrative district as the area for the application of the scheme has already been stressed. This recommendation should not, however, preclude Provincial Governments from choosing a larger administrative unit than a district if such a unit is considered more suitable in certain provinces. We are offering the three-million plan only as a guide to Provincial Governments for working out their own schemes.

17. A three-million district in an area of fairly high density such as Bengal will consist of 150 primary units, each having, on an average, a population of 20,000. About 30 of these primary units can suitably be included in a secondary unit so that the district will have five such units. The strength of staff and hospital accommodation that are recommended for each of the three types of units are shown

below in tabular form. For further details reference may be made to Appendix 2.

### THE LONG-TERM PROGRAMME

#### *Personnel*

	Controlling medical officers	Other medical officers	Non- medical staff	Hospital
Primary unit . . . . .	1	5	78	75 beds.
Secondary unit headquar- ters . . . . .	1	139	358	650 "
District headquarters . .	1	268	1,398	2,500 "

#### **The Primary Unit**

18. In our view preventive and curative health work should be dovetailed into each other in order to produce the maximum results. It is with this idea that the organisation for the primary unit has been devised. As will be seen from Appendix 2 each unit will have six medical officers, six public health nurses and a 75-bed hospital and all these can be utilised for organising a combined curative and preventive health service in the area. Each primary unit is only a link in the chain of the community's health services. The provision of a number of ambulance units in the area controlled by a secondary unit will be necessary in order to facilitate the rapid removal of cases requiring urgent treatment either from places within the area of each primary unit to its own hospital or from primary unit hospitals to the larger institution at the headquarters of the secondary unit. Telephonic connection between the headquarters and individual primary units is also desirable in order to promote promptness and efficiency in the administration of medical aid. Of the six doctors one will be the controlling officer who, in addition to his duties of supervision over the whole staff in the area, will also be the administrative head of the hospital. Of the remaining five medical men at least three will have to work continuously in the hospital in order to provide medical, surgical, obstetrical and gynaecological service respectively.

19. There should be provision for domiciliary treatment of the sick in order to supplement the facilities provided by the hospital. Over and above the hospital nursing staff there will be six public health nurses for rural health work, these being qualified nurses with training in midwifery. Of these four may be put on to preventive work in the homes of the people. Each nurse so engaged should be able to deal with the health of school children, the welfare of mothers and children, tuberculosis work and other activities in the houses within her area of jurisdiction. This will necessitate the provision of a type of nurse who has been trained in all these branches of preventive work. The remaining two public health nurses and two medical officers will be available for the organisation and carrying out of curative treatment in the homes of the people. Due precaution will, of course, have to be taken to ensure that the provision for domiciliary service is not abused. It is desirable that the doctors employed on such service and in the hospital should exchange duties

at intervals. A similar exchange of duties between those public health nurses who are engaged in preventive functions and those engaged in the nursing of patients under the domiciliary treatment scheme seems to be equally desirable.

20. In our view at least two or possibly three of the six medical officers provided in each primary unit should be women. One of them will be employed in the hospital on the gynaecological and obstetrical side. Another will be required for domiciliary duties and a third can with advantage be utilised to supplement the work of the other two in the hospital and outside. It must be remembered that deaths among children under ten years are about 48 per cent. of the total number of deaths at all ages and that maternal deaths contribute an important share to mortality in the country. In the circumstances the health programme must, for a long time to come, concentrate on the welfare of these sections of the population. Further, if the health programme is to produce maximum results, education of the growing children and of mothers in health matters must become an important function of the health service. For both these reasons we should like to see the proportion of women doctors in each primary unit maintained at about 50 per cent. of the total strength.

21. Excluding the hospital staff the remaining members of the primary unit organisation will consist of midwives, sanitary inspectors, health assistants, a fitter mistry and some inferior servants. The functions to be performed by midwives and sanitary inspectors are sufficiently well known and require no special description. On the other hand a few words about the health assistant seem to be desirable.

22. The idea of creating a class of health worker known as 'Health Assistant', has been conceived by us in order to provide a type of personnel for assisting the medical man and for relieving him of many of his minor duties both on the curative as well as on the preventive side. Thus it will be seen from Chapter IV, where our short-term proposals are discussed, that he will assist the Rural Medical Officer of Health in running his dispensary and will also attend to such matters as purification of water supplies, the checking of vital statistics by house to house canvassing, minor anti-malaria works, the spray killing of mosquitoes and other similar duties. During the transition period, the strength of medical and other personnel in a primary unit will be much smaller than under the long-term scheme, and will have to serve a larger population distributed over a wider area. The services of a health assistant can in these circumstances help to extend more widely curative and preventive health care even though it may be limited in scope. It may be asked whether, in the larger scheme under the long-term programme, there will be room for a man of such limited technical skill. It is true that, with the increased facilities for institutional and domiciliary medical care that the larger scheme will provide, there will be less need for the services of the health assistant. But he can and should be made to devote himself more fully to preventive work. His training will no doubt have to undergo suitable alteration. In any case the question of continuing this class of health worker can safely be left to the judgment of the Provincial authorities, when they have acquired sufficient

experience of the nature and quality of the work performed by health assistants.

### **The Secondary Unit**

23. The staff employed at the headquarters of a secondary unit will be considerably larger than that stationed at the headquarters of a primary unit. The Administrative Officer in charge of the secondary unit will be responsible for the supervision and co-ordination of all curative and preventive health work in the unit. He will also have general supervisory control over the 650-bed hospital. The whole-time heads of the different departments of medicine, surgery, maternity, tuberculosis and pathology at the hospital will perform the dual function of attending to the duties of their respective sections in the hospital and of inspecting and guiding such work in the primary unit hospitals.

24. In addition to these, the secondary unit provides for two senior public health nurses and two senior sanitary inspectors who will be responsible for supervising the work of the corresponding officers in the primary unit. We would like to emphasise the necessity for providing adequate office staff to relieve the administrative medical officer and his assistants of purely clerical duties.

### **The District Headquarters Organisation**

25. The provision for medical relief at the district headquarters is, as may be expected, on a much larger scale than that at the secondary unit hospital. The number of beds in the district hospital will be 2,500 and the numbers of medical officers and other personnel employed will also be proportionately larger than in a secondary unit hospital.

26. The secondary unit and district headquarter hospitals, with their better equipment and more highly qualified medical personnel, will be the institutions to which the complicated cases admitted in the primary unit hospitals will be removed. As has already been pointed out, a system of ambulances and telephone connections between all the three types of hospitals will be required to ensure that these institutions are utilised to the fullest possible extent.

27. The health administration of the district will be carried out by the Officer-in-Charge of the District Health Services and by a number of deputies under him who will be responsible for medical relief, public health, environmental hygiene and maternity and child welfare work respectively. A fifth deputy may possibly be found useful for controlling nursing administration. The heads of the different sections in the district hospital dealing with medicine, surgery and so on will mainly be concerned with professional duties. At the same time it will be of advantage if they can occasionally visit the secondary unit hospitals and a certain number of primary unit hospitals and inspect and guide the professional work of officers discharging corresponding duties in these hospitals. Such contacts should help to improve the standard of professional work carried out in the hospitals of the districts generally. It is not desirable that these specialists, in charge of the different sections in the district headquarters hospital, should be burdened with routine administrative and inspection duties especially if the hospital is associated with a teaching medical institution. Hence we have suggested that a number of deputies should be provided to help the district administrative officer in the various fields referred to above.

28. In respect of tuberculosis and leprosy, however, the officer-in-charge of the respective wards in the district headquarters hospital will also have to undertake the organisation and superintendence of field administration in his sphere of work. The Deputy and Assistant Directors of Health Services at the provincial headquarters, who deal with tuberculosis and leprosy, will be responsible for co-ordinating these activities in the province as a whole.

### **The Hospital Social Worker**

29. At all the three types of hospitals, primary, secondary and district headquarters, social workers will be employed. Their functions will include, among others, the visiting of the home of the patient in order to ascertain the causes underlying the disability for which he has sought the aid of the hospital and "service as a connecting link between the hospital and the public in the treatment of the individual patient and the general health programme of the area concerned". It will thus be seen that, under our programme, the treatment of disease has been approached not merely from the standpoint of affording the patient immediate relief but also that of attempting to remove the causes which are responsible for his condition.

### **Part-time Medical Men**

30. A certain proportion of the doctors employed in the secondary and district headquarters hospitals may be part-time workers. Their proportion to the total strength of medical men in these two types of hospitals will not exceed 25 per cent. These institutions will do a considerable amount of teaching. Some of the district headquarters hospitals will be attached to medical colleges while the others and most of the secondary hospitals will have to provide 'refresher courses' for doctors or facilities for the training of those who, after the qualifying examination, are required to take their internship for a year. In addition, these institutions will have to take part in the training of other types of health personnel such as nurses and midwives and will have to run refresher courses for them.

31. In hospitals attached to teaching medical institutions it is considered desirable that there should be a proportion of medical men who combine hospital teaching work with private practice so as to enable them to gain the wider experience that contact with the general public ensures. This type of experience may be lacking in the case of doctors who belong to a salaried service and have only worked in hospitals. We have been advised that there is distinct room for a type of professor who has experience of teaching work and private practice up to the age of about 45 and who then gives up such practice and becomes a whole time teacher. We agree with this view and therefore recommend the retention of a certain number of part-time workers of sufficient eminence from among whom clinical teachers for full-time duties will become available.

32. The scheme, that we have described in the preceding paragraphs, is only one stage, although an advanced stage in comparison with existing conditions, in the development of the national health programme. The conception of the scope of the functions of a community health service has been continually widening and we have no doubt that this process will go on. Side by side with such changes the functions that the doctor will be called upon to discharge will also increase in scope and change in quality. As at present, he will

continue to concern himself with remedial and preventive measures in respect of the sick and the convalescent. We anticipate, at the same time, that his range of duties will extend, to an increasing extent, over the healthy members of the community in order to promote their general sense of well being. Medical supervision of work and play, of the food that people eat, of public provision for rest and recuperation as well as periodical medical examination and the rectification of faulty modes of life will be some of the many new duties that the physician of the future will be called upon to undertake. Our view therefore is that the national health organisation will tend to become a whole-time salaried service devoting itself to the development of the health of the people. The medical men in such an organisation will be recompensed adequately by the State but the supplementing of such income by private practice will be prohibited. The tendency towards this is even now recognisable in all countries by the prohibition that is operative in respect of the preventive health services. Thus there will ultimately be no room for the part-time worker in the State health organisation. But it is impossible for us to see at what time this stage will be reached in India. In the long-term programme described in this chapter we have not therefore excluded the part-time doctor although we have reduced the proportion of such workers to about a fourth of the total number.

### **Hospital Accommodation**

33. The total number of hospital beds provided under our scheme for a population of three millions will be 17,000 or a ratio of 5·67 beds per thousand of the population. If this figure for hospital accommodation can be provided in India within the next thirty or forty years, the achievement must be considered as a remarkable advance on the existing state of affairs. The present total bed strength in British India is estimated to be in the neighbourhood of 73,000 or approximately 0·24 bed per 1,000 population. This ratio will have to be increased about twenty three times in order to reach the proposed figure of 5·67 beds per 1,000.

34. Even this phenomenal increase in the provision of hospital accommodation will not, however, bring India close to the standards that have been reached elsewhere. In the United States of America the corresponding ratio is 10·48 beds and in England and Wales 7·14. It is understood that, in England, with the existing morbidity and mortality rates, the minimum hospital accommodation required is estimated at 10 beds per thousand of the population.

35. It is doubtful whether the ratios for bed strength to population in England and in the United States of America need be accepted, without consideration, as a guide for India. Congested urban conditions of life contribute largely to the desire for hospitalisation even where the state of ill-health may not render it essential. There is every indication that India will become more and more industrialised and urbanised in the years to come, but if proper planning is done, the removal of existing conditions of overcrowding in towns and cities and the prevention of the development of such a state of affairs on a large scale in the future, should not be an impossible task. Further, at the present time, the vast majority of the people are not hospital minded. While it may not be right to postulate that a change in this attitude will not take place, social habits do not alter quickly. In any case an increase in hospital accommodation from the present figure of 0·24 to 5·67 per 1,000 is

itself so stupendous a task that it seems futile to think at present of any future expansions that may be required in the distant future.

36. The distribution of beds that will be made available under our proposals for different types of cases in the primary, secondary and district headquarters hospitals is shown below. The figures are approximate as the calculation is based on a probable population of 375 millions which, it is anticipated, will be reached in British India by the time the proposals under consideration are fully implemented and on the assumption that this population is divided into 125 three-million units of the type described in this chapter:—

*Total provision of beds of various types for British India*

	Primary unit hospitals	Secondary unit hospitals	District headquarters hospitals	Total
1. Medical . . . . .	468,750	93,750	37,500	600,000
2. Surgical . . . . .	187,500	125,000	43,750	356,250
3. Obstetrical and Gynaecological . . . . .	187,500	62,500	37,500	287,500
4. Infectious diseases . . . . .	375,000	12,500	5,000	392,500
5. Malaria . . . . .	112,500	8,250	2,500	121,250
6. Tuberculosis . . . . .	75,000	75,000	67,500	217,500
7. Pediatrics . . . . .	..	31,250	31,250	62,500
8. Mental diseases . . . . .	..	..	50,000	50,000
9. Leprosy . . . . .	..	..	37,500	37,500
				2,125,000

37. Provision for medical, surgical, obstetrical and gynaecological cases is made in all the three types of hospitals and the importance of tuberculosis as a community problem is recognised in the provision of similar facilities for this disease also. For malaria and general infectious diseases, beds are provided in primary hospitals. This will ensure a wide distribution of such facilities, as the number of primary hospitals will be 18,750 or more. Ten and twenty beds have been provided for malaria at each secondary and district headquarters hospital respectively, the corresponding figures for infectious diseases being 20 and 40. These beds will also provide facilities for teaching and research.

38. Provision for patients suffering from mental diseases and leprosy has been made only in the hospitals at the district headquarters. As regards venereal diseases, no specific provision of beds has been made. A large percentage of such cases can be dealt with in clinics associated with the outpatient departments of all the three types of hospitals. The relatively small number requiring hospitalisation can be admitted into the ward for infectious diseases if the patients are in an infective stage or for suitable treatment into the medical, surgical and gynaecological wards.

**Field Organisation for Certain Diseases**

39. Apart from providing facilities for hospital treatment, the control of many diseases requires a field organisation which could concentrate on preventing the spread of infection. Examples are malaria, tuberculosis and leprosy. Malaria is undoubtedly the most important public health problem in the country today and, in our proposals for the short-term programme, we have outlined an

organisation for control measures against this disease on a large scale. It is to be anticipated that, before the long-term programme is completed, the advance made in environmental sanitation will have reduced largely the factors favourable to the propagation of the disease. Indeed, the widespread use of D.D.T. and other insecticides of an even more potent nature, which may be discovered in the coming years, may change the situation to such an extent that it is difficult to see at present what the nature of the malaria problem will be by the time our long-term programme is completed. Even so, it will be unwise to assume that malaria will have been eradicated by that time. The maintenance of anti-malaria measures is likely to be necessary at least in those parts of the country where hyper-endemicity is the prevailing feature today and where climatic and other factors may necessitate the continuance of control activities. The anti-malaria field organisation, whatever size it may assume eventually, will work in close co-operation with the primary unit staff. The Public Health Engineer at the headquarters of the district and his assistant at the secondary unit headquarters will be intimately concerned with the control of the disease through environmental measures. As regards tuberculosis and leprosy, it has already been indicated that the officers in charge of these sections at the district headquarters hospital should direct and control the respective field organisations, although it is difficult to envisage what the size of such organisations is likely to be.

40. The health organisation briefly described in this chapter is expected to produce a reasonably satisfactory service for rural and urban communities alike. It is based mainly on a system of hospitals of varying size and of differing technical efficiency. These institutions will play the dual role of providing medical relief and of taking an active part in the preventive campaign. Diagnostic and treatment facilities of a relatively high order should be available in the secondary unit hospitals and to an even larger extent in those at the headquarters of districts. The latter, if they are attached to medical colleges, should function at a still higher level of efficiency. The wide distribution of primary unit hospitals should help to ensure the extension of facilities for institutional treatment over the countryside. In addition, the outpatient departments of these institutions would extend treatment to a much wider section of the population. In our short-term programme we have provided a dispensary for each primary unit and these institutions will continue even after each such unit has been provided with its hospital. The usefulness of all these centres of treatment will be considerably enhanced by the simultaneous development of transport facilities. To supplement this large scale institutional provision for medical relief we have also envisaged the inauguration of a domiciliary treatment service.

41. The part that these medical institutions will play in the preventive campaign will also be considerable. Work in connection with maternity and child welfare, tuberculosis, leprosy, etc., will radiate into the community from the hospitals, on which will be based the outdoor organisations in respect of each of these services. The diagnostic facilities that the large hospitals will provide will also contribute their share to the preventive campaign. The social workers attached to these institutions will help to supply the preventive bias to the treatment of individual patients, in the absence of which the medical care bestowed on them may fail to produce lasting results.



42. The proposals outlined here emphasise the organic unity of institutional and domiciliary health service and the need for integrating curative and preventive measures in order to develop the health of the community to the highest possible level.

### The Strength of Staff and the Estimated Cost Under the Proposals

43. What are the implications of these proposals in terms of health personnel and of funds? It is impossible to give correct estimates of either. As regards the health staff, exact estimates of the probable strength of the field organisations in respect of many diseases can hardly be made for reasons which have already been stated. In regard to cost, it is clearly unwise to predict what the scales of pay of the different services will be at the end of the next thirty or forty years. The value of the rupee is likely to change within that period, and any estimates of cost of the fully developed health organisation may have, for these reasons, little meaning if employed for comparison with present day figures. The following figures are, however, given for the purpose of providing some general indication of the extent to which the strength of the health staff and the scale of expenditure will have to grow when the health programme outlined above becomes established.

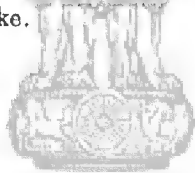
44. As regards health personnel the number of doctors, nurses and midwives that will be required is shown below. The numbers now available are also given for comparison:—

	Numbers required for the complete programme	Numbers now available
Doctors . . . . .	233,650	47,500
Nurses (including public health nurses)	680,000	7,750 (including existing health visitors)
Midwives . . . . .	112,500	5,000
Pharmacists . . . . .	84,375	75

45. Can such a large increase in the numbers of the health personnel be carried out? An example of an unparalleled expansion of health personnel services is furnished by Russia. In 1913, there were altogether 19,785 doctors in that country. By 1941, the number had risen to 141,600, an increase of over seven times within a period of 28 years. In India the increase required is about five times the existing number of doctors to be achieved in a longer period of years. As regards other types of personnel, Russia has shown an equally remarkable increase. For instance, feldshers, a type of medical worker less qualified than the doctor, nurse and midwives totalled about 50,000 in the pre-Revolution days and their number rose to 412,000 in 1941. We believe that, given the will and the financial resources to carry through the required measures, the large additions to the existing strengths of different types of health personnel that will be necessary can be provided within a period of thirty to forty years in India also.

46. The annual average cost of the personal health services described in this chapter will be about Re. 1 *per capita* on the basis of a population of 375 millions. An expenditure of Re. 1 per head of the population for a well developed personal health service cannot be considered excessive.

47. Before we conclude this chapter we wish to emphasise that we look forward to an improvement in the health service not only in its quantitative but also in its qualitative aspect. We believe it essential that, through suitable training and such administrative action as may be necessary, a social outlook should be developed in every health worker and that a spirit of emulation be cultivated throughout the rank and file of the service. We feel that, while it is all important that the man or woman worker should have the best technical skill that it is possible for him or her to acquire, the possession of other qualities is equally important in order to produce effective results. The woman who, through lack of knowledge of mothercraft, feeds, bathes, clothes or nurses her baby improperly, the tuberculosis patient who, through ignorance, disseminates infection, by indiscriminate spitting and coughing, among those with whom he comes in contact, the child who possibly through lack of discipline at home and of that atmosphere of love which is essential for promoting his psychological development on sound lines, has grown into an intractable individual with anti-social habits—all require the technical knowledge and skill that the doctor, the nurse and the social worker can make available to them. But other qualities are also needed in these health workers. Understanding and sympathy, tact and patience are equally important for the proper handling of these persons and, in their absence, mere professional skill will fail to achieve satisfactory results. On the other hand the possession of these qualities will lift the efforts of the health worker to the plane of social service. The reward that flows from the latter enriches the giver and the recipient alike.



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# APPENDIX A

## Central Ministry of Health

(Representatives of the Central and Provincial Governments)

Statutory Central Board of Health

Minister

Central Health Council (Experts)

### DIRECTOR GENERAL OF HEALTH SERVICES

General Administration	Medical Relief		Public Health	Professional Education and Research	Public Health Engineering	Town and Village Planning
	Insurance	Non-Insurance				
1. General administration and co-ordination.	Hospitals, Clinics and Dispensaries.	Hospitals, Clinics and Dispensaries.	1. Communicable diseases.	4. Medical Education including postgraduate training.	1. Water and Sewage control.	(a) Housing.
2. Civil service personnel section.	Mental diseases.	Mental diseases.	2. Nutrition.	2. Dental education.	2. Environmental hygiene in respect of industry—	(b) Slum clearance.
3. Purchase and supplies.	Nursing.	Nursing.	3. School health.	3. Pharmaceutical education.	(a) Control of occupational safety and health hazards.	(c) Zoning.
4. Finance and accounts.	Pharmacy.	Pharmacy.	4. Maternity and child welfare.	4. Public Health Engineering education.	(b) Control of environmental health standards including light ventilation, heat, noise, etc.	
5. Properties.	Medical care for Centrally Administered Areas.	Medical care for Centrally Administered Areas.	5. Industrial health.	5. Nursing education.	(c) Control of offensive trades and stream pollution.	
6. Transport.	Rehabilitation.	Rehabilitation.	6. Visual statistics.	6. Training of auxiliary workers.	(d) Control of smoke nuisance.	
7. Workshops.	Rehabilitation.	Rehabilitation.	7. International quarantine and health.	7. Grants-in-aid.	3. Type Planning—	
	Rehabilitation.	Rehabilitation.	8. Internal quarantine.	8. Research—	(a) Hospitals, clinics.	
	Rehabilitation.	Rehabilitation.	9. Enforcement of standards for biological products and drugs.	1. Undertaken by Government.	(b) Water and sewage.	
	Rehabilitation.	Rehabilitation.	10. Enforcement of standards for food in interprovincial commerce.	(a) Medical subjects.	(c) Housing, etc.	
	Rehabilitation.	Rehabilitation.	11. Administration of Central Government areas.	(b) Public Health Engineering and industrial subjects.	4. Supervision of housing.	
	Rehabilitation.	Rehabilitation.	12. Preventive aspects of mercantile marine.	(c) Social subjects.	5. Control of insects, etc.	
	Rehabilitation.	Rehabilitation.		(d) Biostatistical subjects.	6. Miscellaneous.	
	Rehabilitation.	Rehabilitation.		2. Undertaken by other organisations.	7. Central Water and Sewage Board.	
	Rehabilitation.	Rehabilitation.		(a) Grants-in-aid.		
	Rehabilitation.	Rehabilitation.		(b) Scholarships.		
	Rehabilitation.	Rehabilitation.		(c) Exchanges.		
	Rehabilitation.	Rehabilitation.		3. Survey and planning.		
	Rehabilitation.	Rehabilitation.		4. Library, journals, publications and translations.		
	Rehabilitation.	Rehabilitation.		C. All-India organisations—		
	Rehabilitation.	Rehabilitation.		(a) Medical Council of India.		
	Rehabilitation.	Rehabilitation.		(b) Nursing Council of India.		
	Rehabilitation.	Rehabilitation.		(c) All-India Dental Council.		
	Rehabilitation.	Rehabilitation.		(d) All-India Pharmaceutical Council.		

## APPENDIX B

### Provincial Ministry of Health

Representatives of the Provincial Government and of local bodies)		Minister		Provincial Health Council (Experts)	
DIRECTOR OF HEALTH SERVICES					
General Administration		Medical Relief		Public Health	
Insurance		Non-Insurance		Public Health	
Hospitals, Clinics and dispensaries.		Hospitals, Clinics and dispensaries.		Communicable diseases.	
Mental Hospitals and Clinics.		Mental Hospitals and Clinics.		Epidemiology.	
Nursing.		Nursing.		Vital Statistics.	
Pharmacy.		Pharmacy.		Maternity and child-welfare.	
Rehabilitation.		Rehabilitation.		School health.	
Nursing.		Nursing.		Industrial health.	
Pharmacy.		Pharmacy.		Veneral diseases, tuberculosis and other personal health services.	
Rehabilitation.		Rehabilitation.		Nutrition.	
Enforcement of standards for biological products and drugs.		Enforcement of standards for biological products and drugs.		Enforcement of standards for food.	
Provincial and Regional centres; production and distribution of biological products.		Provincial and Regional centres; production and distribution of biological products.		Provincial Medical Council.	
Provincial Nursing Council.		Provincial Nursing Council.		Provincial Pharmaceutical Council.	
Provincial Dental Council.		Provincial Dental Council.		Provincial Water and Sewage Board.	
Water and sewage control.		Water and sewage control.		Water and sewage control.	
Industrial engineering :		Industrial engineering :		Industrial engineering :	
Control of special safety and occupational hazards.		Control of special safety and occupational hazards.		Control of special safety and occupational hazards.	
Control of environmental health standards including light ventilation, heat, noise, etc.		Control of environmental health standards including light ventilation, heat, noise, etc.		Control of environmental health standards including light ventilation, heat, noise, etc.	
Control of offensive trades and of stream pollution.		Control of offensive trades and of stream pollution.		Control of offensive trades and of stream pollution.	
Control of smoke nuisance.		Control of smoke nuisance.		Control of smoke nuisance.	
Type planning :		Type planning :		Type planning :	
Hospitals, clinics.		Hospitals, clinics.		Hospitals, clinics.	
Water and sewage.		Water and sewage.		Water and sewage.	
Housing, etc.		Housing, etc.		Housing, etc.	
Supervision of housing.		Supervision of housing.		Supervision of housing.	
Control of insects, rodents, etc.		Control of insects, rodents, etc.		Control of insects, rodents, etc.	
Miscellaneous.		Miscellaneous.		Miscellaneous.	
Provincial Water and Sewage Board.		Provincial Water and Sewage Board.		Provincial Water and Sewage Board.	

*Note.*—It is the considered opinion of the Health Survey and Development Committee that housing, slum clearance, zoning, etc. are of sufficient importance to necessitate the creation of a Ministry of Town and Village Planning in each province.

## CHAPTER IV

### HEALTH SERVICES FOR THE PEOPLE

#### The Short-Term Programme

##### Introduction:

1. In the last chapter we have described a long-term scheme of health services for the country as a whole, which will provide health protection for the community on a much larger scale than that which exists at present and will include within its scope domiciliary and institutional services, curative and preventive, on lines which follow modern trends of medical practice. We consider that, given the resources, human and material and the determination to implement this programme, it should be possible for Governments in the country to develop these services within a period of thirty to forty years. Two serious difficulties in the way of a rapid development of our health programme are inadequacy of trained health personnel to man these services and lack of funds. The question of training the required personnel will be dealt with in the section dealing with professional education. As regards funds we hold the view that the health programme demands very high priority in the allocation of available financial resources. Apart from the intrinsic importance of maintaining individual and community health at its highest level, we strongly hold the view that the carrying out of the health measures we propose is one of the most effective ways of ensuring the economic prosperity of the country and of materially raising the level of the national income. It is obviously impossible to assess accurately, in terms of money, the effects of ill-health on the community. While certain items such as loss of wages through incapacity to work and the expenses incurred in treatment can be estimated with some degree of preciseness, the pain suffered, the inconvenience and anxiety caused to the patient and his relations or the sense of well-being that would have prevailed in the absence of sickness are obviously insusceptible of conversion into money. Nor can any accurate estimate be made of the financial loss that the country suffers as the result of decreased productivity through sickness. Nevertheless, in order to give some idea of the magnitude and importance of this problem we should refer to the estimate made by Lieut.-Colonel J. A. Sinton, who places the annual loss to India on account of malaria alone anywhere between 147 and 187 crores of rupees. Enormous though this estimate is, it does not pretend to cover all losses attributable to this disease. If to these figures were added the valuation of losses consequent on malnutrition and the many serious diseases other than malaria, which are widely prevalent in the country, we are presented with the most convincing argument we can find in support of our contention that, even if the question is regarded from the purely financial standpoint, expenditure of public funds on an effective health development programme is a sound economic proposition. To shut our eyes to the consequences which a halting, ineffective and timid health policy imposes on the country can only result in perpetuating a tragedy which is as poignant on the national as on the individual side.

2. No useful purpose will, however, be served by ignoring or bypassing realities and in framing any practical programme we have

to take account of the limiting factors of lack of funds and of trained personnel, which in the early stages must impose a brake on rapid progress. The first consequence is that the health programme which we eventually visualise for the whole country must initially be introduced in an attenuated form and must be developed by stages. Any scheme which may be introduced must, however, be of such a nature that, if effectively executed, it will be able to ensure the production of demonstrable results during the period covered by it. In framing our short-term programme we desire to do no more than present a detailed picture for the general guidance of the provinces. We realise that local conditions may call for a modification of some of its features. We recognise that varying resources in men and money will be reflected in the pace at which the health programme can be developed in the different provinces. We believe, however, that despite factors making for a limited diversity in its practical application the depiction of a general plan of development will serve an essential purpose. It will help to define a more or less uniform goal for the country which we consider of great importance and will serve to point out the level of achievement to be normally reached within specific periods of time. Such a schedule will also assist, we have no doubt, in stimulating effort in the provinces and in developing a spirit of friendly emulation among them in promoting the health of their people.

3. We have framed our suggestions for a short-term programme after taking into account the limitations to which we have referred. We shall now describe in some detail the picture of the health organisation that we suggest should be developed during the first ten years and indicate in much broader outline certain objectives that may be kept in view during the next five years. The detailed programme will cover two stages of five years each and we shall indicate the implications of our scheme in terms of personnel, cost and the population covered by the health services during each of these quinquennia. Apart from providing new facilities for medical care for the people, these two periods will constitute a stage of intensive preparation for the subsequent development of the health programme at a more rapid pace, through the provision, in these earlier years of institutions and other opportunities for the training of personnel and through the actual production of a large number of health workers of different categories.

4. Another important aspect of the health programme for the first ten years is that it will be intimately concerned with the development of administrative technique suitable to this country. Health administration is the application of medical knowledge to the life of the community, and the methods to be employed in its application are largely influenced by the attendant social, economic and environmental factors. These methods have therefore to be worked out in relation to local conditions. The skilled services that can be provided for this purpose in countries such as the United Kingdom and the United States of America, with their relatively large national incomes, are obviously unattainable in India today and the health programme that we are envisaging must take account of this basic fact. In the beginning the country will be faced with the necessity of having to some extent and in some fields to put up with services manned by

imperfectly trained personnel with the ability to perform only limited functions. This subject will be discussed in greater detail later in this chapter.

5. We have already referred to the considerations which make detailed planning inadvisable too far in advance, and we feel that we should therefore limit ourselves to the task of drawing, with some degree of precision, the picture of our short-term programme for the first ten years only. After the earlier stages of expansion indicated in the present chapter have been reached we feel that we must leave it to the Governments, Central and Provincial, to formulate the lines of further development with a view to the attainment of the larger objectives indicated in the preceding chapter.

6. We wish to make it clear that the proposals that will be discussed in the succeeding paragraphs embody recommendations which are intended to supplement and not supplant the existing health facilities in the areas where our scheme will be introduced. We consider, moreover, that our recommendations constitute an irreducible minimum, and, were it not for the limitation imposed by the inadequacy of staff and funds, we should unhesitatingly have proposed a more comprehensive scheme than the one indicated below.

7. In the previous chapter we have described the organisation required to provide a reasonably complete health service for the community. For reasons which we have already stated, however, it will be necessary to cast our short-term programme on more modest lines. Thus, during the first ten years, the district headquarters organisation provided in our long distance plan, will not be brought into existence. Further, the services provided in the primary and secondary health units during this period will not be so complete and comprehensive, owing to the limitations to which we have already referred, as we hope they will be in the later stages of our scheme. But the general character of the work to be done in the primary and secondary health units during the short-term programme and the relation of these units to each other will be the same in the short as in the long-term programme. The general description of the organisation set out in the preceding chapter, read with this caveat, is applicable to the organisation which will operate in the ten-year period.

### **The First Ten-Year Programme**

8. The following brief summary of the major heads of the ten-year programme we are suggesting may enable the detailed proposals which follow to be more clearly understood.

Our recommendations cover:—

I. A province-wide health organisation providing for both preventive and curative health work. This will include in each district:—

- (i) three types of organisations for general health services,  
*viz.*,
  - (a) primary health units
  - (b) secondary health units
  - (c) the district health unit,

## (ii) certain special health services dealing with

- (a) malaria
- (b) tuberculosis
- (c) venereal diseases
- (d) leprosy
- (e) mental diseases
- (f) maternity and child-welfare
- (g) school health and
- (h) nutrition.

## II. Field training centres for teaching institutions.

Our proposals for the ten year programme cover also recommendations in regard to a variety of other matters such as Impersonal Health Services, including town and village planning, housing, water supply and drainage, professional education and medical research. They will be found in the separate chapters dealing with these individual subjects.

We shall now examine these proposals in greater detail separately.

**The Province-wide Health Organisation**

9. At the outset we were faced with the difficult problem of deciding whether our proposals should at the start be applied in a narrowly restricted locality to the fullest extent that circumstances permitted or whether the area of their application should be extended much more widely at the expense of the degree of their application. We have come to the conclusion that the new health services, in howsoever attenuated a form they may be started, should be initiated on as wide a territorial basis as possible. We feel that, for the purpose of demonstrating the resulting improvement in the public health of a province as a whole, the application of our proposals in every district, though it may be over a limited area in each to begin with, will be more effective than concentration of effort in one or two small areas in the province. Further we feel that all parts of a province should, from the commencement, have an opportunity of sharing, even though it be to a limited extent, the benefits which we hope that our proposals will bring to the people. We also realise that Provincial Ministers of Health will have to carry popular support with them in the development of the scheme and that public opinion is much more likely to support a broad-based proposal than one which would confine the new health organisation to one or two districts in a province. The objectives to be reached at the end of the first ten years are indicated below:—

*Expansion of the scheme in a typical district*

	First year	Fifth year	Tenth year
Number of primary Units . . . .	5	10	25
Number of 30-bed hospitals . . . .	1	2	13
Number of secondary Units . . . .	1	1	2
Number of 200-bed hospitals . . . .	1	1	1
Number of 500-bed hospitals . . . .	..	..	1

**The Primary Unit**

10. We recommend that a start should be made with five primary units in each district. Each of these should include within its scope



a population of 40,000 in place of the much smaller and more fully staffed and equipped unit serving a population of 10,000 to 20,000 recommended for the long-term programme. In place of a 75-bed hospital for each primary unit under the fully developed long distance scheme, we suggest that, during the first five years of the short-term programme, one 30-bed hospital should be established to serve four primary units. In the second period of five years the number of such hospitals should be doubled so that each will serve two primary units. In addition each primary unit will have a dispensary with provision for two emergency and two maternity beds.

11. The smaller type of health organisation that is proposed in each short-term primary unit and the larger number of people to be served by it will obviously limit the range of activity. The service developed, however, will, it is hoped be on correct lines and will incorporate curative and preventive work on a coordinated basis. The details of the proposed organisation for the short-term primary unit are given below:—

Medical officers . . . . .	2
Public Health Nurses . . . . .	4
Nurse . . . . .	1
Midwives . . . . .	4
*Trained <i>dais</i> . . . . .	4
Public Health inspectors . . . . .	2
Health assistants . . . . .	2
Pharmacist . . . . .	1
Clerks . . . . .	2
Fitter Mistry . . . . .	1
Inferior servants . . . . .	15

12. This staff, with the exception of certain members of the maternity and child-welfare organisation, should be stationed at the headquarters of the primary unit, although their duties will extend over the whole area covered by the unit. The maternity and child-welfare staff, namely, the public health nurses, the midwives and trained *dais*, should, on the other hand, be located at different places in order to make their services available where required with the least possible delay. The other members of the primary unit staff should also have their areas of jurisdiction demarcated, although they themselves would be located at the headquarters.

### The Primary Health Centre

13. A focal point should be provided in each primary unit from which the different types of activity will radiate into the area covered by it. The area of the unit might, for purposes of health administration be divided into four circles, one being associated with the headquarters of the unit. Here it is essential that the dispensary, the headquarters maternity and child-welfare organisation and that dealing with environmental hygiene should work together in intimate association and for this purpose the necessary buildings should be provided in the closest possible proximity to each other. This will also help to coordinate the work of the different members of the staff. This organisation at the headquarters of the unit may appropriately be designated the health centre. Its functions will be to provide as effective a health service as practicable under the conditions prevailing

\*A *dai* is a woman who practises midwifery as a hereditary profession normally without any training.

at the time, both at the headquarters and in the remaining circles into which we have suggested that the primary unit area should be divided.

### The Duties of the Primary Unit Staff

14. The staff recommended above is, we believe, the minimum required for the efficient working of the centre. Of the doctors one should, if possible, be a woman and both should attend to curative and preventive duties. We suggest the following tentative programme of work for these doctors, which, however, will be subject to revision in accordance with local needs. For four hours in the mornings on three days in the week each of them will attend the dispensary attached to the primary unit and, in the afternoons of those days and during the forenoons and afternoons of the remaining three working days of the week, each will attend to preventive work. On the days on which the man doctor attends the dispensary the woman doctor will be on outdoor duty and *vice versa*. Each should have one day of rest in the week, although both will have to be available for any urgent calls that may arise.

15. At the hospital the man doctor will normally attend to male patients and the woman doctor to patients of her own sex and to children. Each primary unit should have two health assistants on its staff. The kind of work they should be required to perform has been referred to briefly in the last chapter. The Health Assistant should perform both curative and preventive duties of an elementary nature under the direction of a qualified medical officer. He should in no circumstances be considered a doctor or allowed to function as such. On the curative side he can help the doctor in the dispensary in sterilising instruments, dressing wounds, keeping records and such other duties as can safely be entrusted to him. His outdoor duties should include the sterilisation of water-supplies, vaccination against small-pox, checking of vital statistics, supervision of minor anti-malaria field operations, including the spray-killing of mosquitoes, and the tracing of cases of the common infectious diseases. If suitable women can be obtained for training as Health Assistants, it will be desirable to have a man and a woman worker of this type in each primary unit. As the woman doctor will deal with women and children both at the dispensary and in the homes of the people the help of a woman assistant will be of great value.

16. At each dispensary there will, in addition, be a trained pharmacist, when this class of worker becomes available in sufficient numbers. In the meantime a compounder will be employed.

17. We consider that a combination of curative and preventive health work is in the best interests of the community and of the professional efficiency of the medical staff employed. In fact the two functions cannot be separated without detriment to the health of the community. For instance our primary unit doctor treating a typhoid patient in his home should, in addition to the medical attention he gives him, ensure that such precautions are taken as are necessary to prevent the spread of infection to the other members of the household. Nor should his responsibility end there. In the interests of the community it is necessary that the sources of infection should, if possible, be discovered in order to prevent the further spread of the disease. It is therefore essential that he should deal with the problems

of disease both in its remedial and preventive aspects. The same remarks apply to the public health nurse and other members of the organisation who are responsible for personal health services in their respective spheres.

18. We consider it essential that the doctors should be spared all unnecessary clerical work, especially because during the short-term programme they will be fully occupied with the duties we are assigning to them. We have, therefore, provided in our budget estimates two clerks, of whom one will assist the man or woman doctor in making and maintaining records in regard to the patients treated in the dispensaries and the other will do all the clerical work in connection with the administration of the primary unit. It will be desirable to give these clerks special training for a short period in order to enable them to familiarise themselves with medical and other technical terms commonly used in health administration.

19. We place maternity and child-welfare work in the forefront of our programme. As has been pointed out elsewhere, nearly half the number of total deaths in the community occurs annually among children under 10 years, while deaths due to maternal causes are estimated at about 200,000 per year. At the same time a much larger number of women are compelled to suffer varying degrees of sickness and disability as the result of pregnancy and childbearing. The supreme importance of dealing without delay with this section of the population is, therefore, obvious. Further, in our view, a progressive improvement of the public health depends largely on promoting the hygienic mode of life among the people through education directed to this end. It is among women and children that this education should be carried out intensively in order to produce lasting results. The woman doctor, the public health nurse and the midwife can carry the message of health to the homes of the people through the numerous contacts which they will establish with women and children while carrying out their routine duties. We are therefore convinced that the part that the maternity and child-welfare organisation can play in reducing existing morbidity and mortality and in creating conditions, which are essential for promoting healthful living, is of vital importance.

20. Of the remaining staff, the sanitary inspector and the inferior servants will be concerned with improving environmental conditions. The fitter mistry's duty will be to help in keeping in good repair tube wells and other sanitary equipment which will be provided under the health programme. The work of the sanitary staff will be under the close supervision of the medical officer charged with administrative duties of the unit. In addition, as will be seen later from the description we give of the organisation at the secondary unit, there will be an Assistant Public Health Engineer at the headquarters of the latter and this officer will be responsible for the requisite technical guidance and for general supervision of all work in respect of environmental hygiene in the primary units included within the jurisdiction of the secondary unit. We realise that the staff proposed for this important branch of health administration is altogether too meagre to meet the requirements of a primary unit as we conceive its functions to be. But we look to the people themselves to make an effective contribution to the public health by helping in the execution of measures for its improvement. In this task the trained staff we are providing,

small though it is, will be of the greatest value in showing the people how their efforts can be made to produce the best results.

21. We have already referred to the need for employing, during the short term, insufficiently trained personnel of certain types if the health services are to be extended to as large a section of the population as possible. For instance, in order to promote school health work, the services of selected school masters, with limited training in the carrying out of certain simple functions, not requiring any high degree of technical knowledge, will have to be utilised in the place of doctors and nurses until the latter become available in sufficient numbers to provide a more efficient service. The duties for which teachers should be trained may include the daily examination of school children in order to improve the standard of their personal cleanliness, vaccination against small-pox, the administration of certain drugs, *e.g.*, quinine, supervision of the sanitation of the school and its environment and the health education of the children within limited fields. For performing such duties they should, of course, receive adequate extra remuneration. One of us (Dr. J. B. Grant) has had considerable experience, during the past year and a half, of developing a rural health organisation in the Singur area of Hooghly District in Bengal in order to provide a training centre for the health personnel of that province as well as for the students of the All-India Institute of Hygiene and Public Health, Calcutta. The experience gained at this centre makes it clear that a limited training of seven or eight weeks will not of itself enable school masters to discharge satisfactorily the duties suggested by us without close supervision. It has, for instance, been found necessary for the medical officer in charge, to make a teacher carry out vaccination and other duties in his presence for some time after his training, in order to ensure that a desirable level of efficiency is attained. The two doctors in charge of the primary unit will therefore have to exercise considerable supervision over the work of teachers and other people selected from the villages to help in the promotion of the health programme. Hence it is that we have allotted the major part of their weekly programme to outdoor duties and have suggested the attendance of each at the dispensary only during the forenoons on three days in the week.

22. Most of the medical men, who will be available to Provincial Governments for developing the early stages of our health programme, will not have had the training necessary for preventive health work. It is therefore recommended that a short course of three months' training in public health and preventive medicine should be provided for them. They should, however, be required to obtain a recognised public health qualification within the first five years of entering public service.

### **The Emphasis on Preventive Health Work in our Programme**

23. We realise that the need for medical relief is so great and so urgent in this country that our proposal to make these medical officers concentrate so largely on preventive work may meet with criticism. We have, however, made this recommendation after careful consideration. Our view is that, with the limited staff and funds at the disposal of the country, our health programme will show more effective and lasting results if effort is directed towards the creation of conditions conducive to healthful living instead of concentrating too largely

on the administration of medical relief. The extent of sickness prevalent in India today is so large that any conceivable expansion of treatment facilities, which the country can afford under existing conditions, will suffice to provide for the relief of only a small fraction of those requiring such care. Sickness surveys carried out in the United States of America have shown that illnesses causing inability to work for seven or more consecutive days number every year about 125 to 200 in a population of 1,000. A similar investigation in Canada revealed that the corresponding figure was 171 illnesses for 1,000 persons. These illnesses clearly require medical attention. The death rates in Canada and the United States of America are less than half of that in India, and it seems, therefore, reasonable to assume that the corresponding sickness rate for this country may be between 300 and 350 illnesses per year among 1,000 persons. A primary unit may therefore have to deal with about 12,000 to 14,000 such cases annually. These will include many cases of serious illness and of chronic disease, so that the period during which medical attention will be required by individual patients may be considerable. Further, as persons suffering from sickness of shorter duration than one week have been left out and as a certain proportion of them will also require attention, the number of cases needing medical relief may well be at least 20,000 to 25,000 per year in each primary unit. The fact that we are not making here any excessive estimate is shown by the case rate of 1,000 per year for a population of 1,000 which the above mentioned enquiry in the United States of America revealed, when all types of illnesses were taken into consideration.

24. We have quoted these figures only to show that, if all the available money and staff were to be utilised only for the provision of medical relief, we should be meeting the needs of only a section of the population requiring such care under present conditions and those which can be foreseen in the near future. Apart from this, no advance will have been made in the neutralisation of the adverse effects of those social and environmental factors which are so largely responsible for morbidity and mortality and without the control of which no permanent improvement in the public health can be achieved.

25. We are fully aware of the need for extending medical relief to all those who are suffering from disease. Nevertheless, when the problem of building the nation's health is viewed in its true perspective, we are compelled to come to the conclusion that the health programme should be developed on a foundation of preventive health work and that such activities should proceed side by side with those concerned with the treatment of patients. We have, however, made such provision as is possible under existing conditions, for medical relief also. We anticipate that the successive stages of the health programme will see a steady expansion of treatment facilities as an essential complementary service to preventive health work. We should, however, emphasise that a reduction in the demand for curative treatment can only be secured through successful preventive work.

#### **The Establishment of Village Committees**

26. We have already referred to the need for securing the active co-operation of the people in the development of the health programme. Social customs, habits and prejudices, which stand in the

way of progress, must be modified. In the words of Sir George Newman, "No far reaching medical reform is separable from social reform, which in its turn finds its source in the highest aspirations of the people."\* Today the vast majority of the people of India view with apathy the large amount of unnecessary suffering and morbidity that exists in their midst and, unless this attitude can be replaced by one of active cooperation among themselves and with the health authorities for the promotion of the health of the community, no permanent success can be achieved. The most effective way of helping to create such a change in outlook is, we believe, by providing for the people opportunities of active participation in the local health programme. As far as we are aware, nowhere has this idea been developed to the same extent as in Soviet Russia. The following quotation from Professor Henry E. Sigerist's "Socialised Medicine in the Soviet Union" illustrates the way in which the health programme in Russia provides for the participation of the people on a wide front:—

"The health programme is not dictated from above, but is, on the contrary, administered in the most democratic way. Since the principle has been established that the health of the workers is their responsibility, it is logical for them to take a large and active part in the administration of health. Health administration, like every branch of Soviet administration, has the form of a pyramid with an exceedingly broad base. This broad base is new to the world. In capitalist countries health administration does not go beyond the municipal or the country health department. It is the concern of specialists. The people are the object of administration and have no share in it. In the Soviet Union the base of the health pyramid is formed by innumerable health committees or health nuclei organised in every factory, every farm, wherever people work."

27. India resembles Russia in its size and population and we feel that a large number of local health committees or health nuclei will, in this country also, help to secure results comparable with those which we understand have been achieved in that country. We suggest that, in every village, there should be established a health committee of voluntary workers consisting of about five to seven individuals depending on the size and population of the village. The principle of the *panchayat* or a council of five elders who, through their collective wisdom, direct community life in the village has long been applied in practice in India. We desire to see local health committees set up on this principle of bringing together a certain number of persons of standing in the village who can be helpful in promoting specific lines of health activity. In selecting such persons we do not wish to bring in the vote and the spirit of competition for the vote which however desirable it may be for conferring on these individuals the right of claiming to be representative of the people, has also the disadvantage of introducing into the peaceful atmosphere of cooperative effort, which we are proposing to create, the heat and controversy of the political arena. At the same time there should be a large

\*"An outline of the Practice of Preventive Medicine" By Sir George Newman a memorandum addressed to the Minister of Health, England & Wales.

measure of popular support for these individuals. We suggest therefore that the two medical officers and their subordinate staff should carry out, before attempting to create these village committees, a considerable amount of educative work among the people in regard to the proposed health programme and the desirability of the more public spirited in the community accepting as a privilege the right to associate themselves with the activities of the health organisation in the interest of promoting the welfare of all. After such preliminary work, during which they will probably be able to pick out the men and women who are likely to become suitable members of the proposed committee, a meeting of the village people should be called and the purpose in view in forming the committee and the work that will be expected of its members should be explained. Then, as a result of the discussions that follow, it may be expected that suitable persons will be selected with the general approval of the villagers. In putting forward these proposals we are not merely theorising or drawing on our imagination. We understand that this method has been tried in Singur with a considerable measure of success.

28. Where village *panchayats* constituted by law exist, it may be found possible to utilise their services for the purpose we have in view.

29. The members of the village committee will, of course, require training in the elementary functions they will be called upon to perform. These functions should not be of too complicated or technical a character, nor should they take up too much of their time. The special value of these persons lies in the fact that their standing in the village, their local knowledge and intimate contact with the people will enable them to influence the villagers to accept and help to carry out effectively the health measures designed to promote the general welfare. Opposition due to social or religious prejudices is likely to yield more easily to the advice given and the example set by the members of the village committee than to official action.

30. These committee members should also be able to induce the village community to carry out, without payment and through their own effort, many measures which might otherwise prove expensive. We have in mind such minor sanitary works as the filling of pools, the draining of pits and the removal of rank vegetation in order to improve the sanitation of the village site. Such works are of particular importance in the areas which are subject to outbreaks of malaria.

31. There are many other directions in which the mobilised goodwill of the community can assist the health programme. The general lack of cleanliness in villages is due to the absence of any organised effort to dispose of refuse and nightsoil in a manner which will render them innocuous to the health of the people. The general belief seems to be that what is undesirable in one's own premises can, without any compunction, be thrown into a public drain or any common open space. This lack of regard for community hygiene can be remedied only by an awakening of a health consciousness among the people. Experience shows that, in the absence of such awakening, improvement in the sanitation of the environment is difficult and often impossible even with the provision of appropriate public services.

32. Each member of the village committee should be assigned a definite task. One individual may, for instance, be made responsible for improving the registration and local compilation of vital statistics. His association with these duties will, we have no doubt, help to ensure greater completeness in the recording of births, deaths and cases of infectious disease. This member of the committee, if he takes this work seriously, can help to promote a greater sense of responsibility among his fellow villagers for reporting such events to the proper authority. Another member of the committee could interest himself in village sanitation while a third might render active assistance to the health staff in the carrying out of measures against communicable diseases or in the organisation of special steps against threatened outbreaks of such diseases during fairs and festivals, after floods or under other abnormal conditions.

33. We need not go into the details of the many ways in which an enthusiastic local committee can help to improve the health of the village. In our view, the development of such local effort and the promotion of a spirit of self-help in the community are as important to the success of the health programme as the specific services which the trained health staff will be able to place at the disposal of the people.

#### **Average Area of, and Average Number of Village in, a Primary Unit**

34. Before we close this description of the health organisation in a primary unit we may draw attention to two factors which have a bearing on the efficiency of the health service that will be made available to the people. These are the average areas over which the proposed population of 40,000 in a primary unit will be spread in the initial years, and the number of villages likely to be included under its jurisdiction. The relevant figures are given below:—

*Average number of villages and average area for a population of 40,000*

(Figures based on the 1941 census)

Provinces	Villages	Area in square miles (including towns & villages)
Madras . . . . .	38	103.2
Bombay . . . . .	59	146.6
Bengal . . . . .	67	51.2
U. P. . . . .	85	77.2
Punjab . . . . .	61	128.8
Bihar . . . . .	83	76.4
C. P. and Berar . . . . .	106	234.1
Orissa . . . . .	127	235.0
N.W. F. P. . . . .	51	96.2
Assam . . . . .	136	178.0
Sind . . . . .	75	215.8
		424.6

35. In the more sparsely populated provinces such as the Central Provinces and Berar, Assam, Sind and Orissa the area to be covered by the health staff is considerably greater than that in the more densely populated provinces of Bengal, Bihar and the United Provinces. The average number of villages that will be covered by each primary unit will also vary considerably. The need for ensuring adequate service by the staff must be prominently kept in view. In addition the supervising officers should be able to exercise effective control over the work of their subordinates. This is a matter of the



utmost importance. In our view the two medical officers of a primary unit should be able to visit each village at least twice or, better still, three times a month. In the circumstances it seems likely that the figure of 40,000, which we have suggested, may have to be modified in individual provinces in order to suit local conditions. This figure has been suggested only as a guide to Provincial Governments. We have been compelled to adopt it in the initial stages of our programme because, with the numbers of trained staff under certain categories, which are likely to become available, particularly during the first ten years of the programme, it is impossible to provide for more concentrated work by reducing the area and size of the population covered by a primary unit. In fact, as has been shown elsewhere, the training programme will have to be started well in advance of the inauguration of the proposed health scheme. Even if this is done, only a portion of the required staff is likely to become available.

### Secondary Unit

36. A secondary unit should be established in each district from the commencement of our programme. It will supervise the work of the primary units included in its sphere of control, which will number five to begin with and will increase to 12 or 13 by the end of the ten-year period. The work of a secondary unit will be concentrated in a secondary health centre located at its headquarters and will include (a) the supervision of the health work done in the primary units within its charge, (b) the control of the 30-bed hospitals in those units and (c) the provision of a higher type of medical service than that provided in the primary units.

37. For providing medical relief of a higher type than that available in the 30-bed hospitals and in primary unit dispensaries there will be a 200-bed hospital at the headquarters of the secondary unit. In addition to the staff attached to the hospital, there will be a medical officer responsible for the administration of the whole area under the jurisdiction of the secondary unit as well as officers for organising and supervising certain specific branches of health activity. The composition of the senior members of the staff is shown below.

For details reference may be made to appendix 3:—

#### *Administrative staff—*

Administrative Medical Officer . . . . .	1
Dy. Administrative Medical Officer . . . . .	1
Assistant Administrative Medical Officer (Maternity and child welfare) . . . . .	1
Assistant Public Health Engineer . . . . .	1
Senior Sanitary Inspectors . . . . .	2
Senior Health Visitors . . . . .	2

#### *Hospital staff—*

Medical Officer in charge of medical wards . . . . .	1	} (Of these one will perform the functions of the Superintendent of the hospital)
Medical Officer in charge of surgical wards . . . . .	1	
Medical Officer in charge of obstetrical and gynaecological wards . . . . .	1	
Medical Officer in charge of the laboratory . . . . .	1	
Assistant Medical Officers attached to the laboratory . . . . .	2	
Senior Medical Officer in charge of the X-ray department . . . . .	1	
Assistant Medical Officer attached to the X-ray department . . . . .	1	

# CHAPTER IV

House staff . . . . .	6	(two for each of the medical officers in charge of medical, surgical and obstetrical wards).
Part-time doctors . . . . .	3	(one for each of the medical, surgical and obstetrical wards).
Orthodontal surgeon . . . . .	1	
Dentists . . . . .	2	
Dental hygienists . . . . .	4	

We would once again lay emphasis on our conception of the medical officer of the future as one who combines in himself both curative and preventive functions. In the selection of officers to fill administrative posts we would stress the importance of bearing in mind the considerations we have set out in Chapter XVII para. 26.

38. In providing administrative machinery for the secondary unit and its associated primary units, we have to remember that, during the short-term programme, the scheme will extend only over certain parts of individual districts and that the administration of the area covered by the proposed new health services will have to be integrated with the health organisation of the district as a whole. This problem of integration is primarily one for the Provincial Governments to solve. We are, however, putting forward the following suggestion for consideration:—

We envisage the bringing together of the Medical and Public Health Departments under one administrative head at the headquarters of each province. In order to ensure the orderly development of the new health services, this recommendation will have to be implemented, we believe, from the very beginning. As a corollary to the amalgamation of the two services at the top we consider that district health administration should also be unified under one controlling head whose designation may appropriately be the Officer in Charge of the District Health Services. His functions will be twofold during the period of development of the health programme. He will have to be responsible for the continuance of the existing health services in the areas untouched by our scheme and he will also have to devote a considerable part of his time and attention to the development of the new services. We need not deal here with the health services in the area unaffected by our scheme. As regards the developmental area we propose that the Administrative Medical Officer at the headquarters of the secondary unit, who will be concerned with the coordination of curative and preventive health work under the scheme, should function as a Deputy to the Officer in Charge of the District Health Services.

39. The other administrative officers attached to the secondary unit will be responsible for the functions indicated by their respective designations. Their jurisdiction will extend over the whole area controlled by the secondary unit and they will work under the supervision of the Administrative Medical Officer.

40. It will be seen that no provision has been made for the supervision of medical relief activities. The Administrative Medical Officer will himself participate in such supervision. In addition, we recommend that the medical officers in charge of the medical, surgical and obstetrical wards should make periodical inspections of the hospitals and dispensaries in the area covered by the scheme and that they should, by advice and guidance, endeavour to raise the level of efficiency of the services provided for the people in their respective fields.

41. One of the four medical officers in the hospitals will function as the Superintendent. We suggest (*vide* appendix 8) that the Superintendent should have the same salary and status as the Deputy Administrative Medical Officer in charge of Public Health. The Medical Officer in charge of the obstetrical and gynaecological wards should be a woman.

42. The Assistant Administrative Medical Officer in charge of maternity and child welfare work and the woman doctor in charge of the obstetrical and gynaecological wards in the hospital should have the same status and pay. We suggest that there should be a periodical exchange of duties between these two. Such exchange is in the interests of both. The person, who directs domiciliary health work among mothers and children, should have periodical opportunities of doing clinical work in the hospital, while the doctor in the hospital will widen her social outlook and her range of experience by coming into contact with the homes of the people and with the environmental and other factors that are associated with the conditions of ill-health which take the patients to hospital.

43. We attach great importance to the provision of a laboratory service in association with the 200-bed hospital. The medical officer in charge of the laboratory and his two assistants should be able to provide a service covering the fields of pathology, bacteriology and bio-chemistry. Apart from meeting the needs of the hospital, specimens sent from other medical institutions, in the area controlled by the secondary unit, should also be dealt with here. We further suggest that this laboratory should provide a diagnostic service, particularly in relation to infectious diseases, for the general medical practitioners in the area. The service should be given free in the interests of promoting the public health and of encouraging the medical men in the area to adopt scientific methods of diagnosis. It is difficult to estimate the amount of work that this laboratory may be called upon to undertake but we suggest that a beginning should be made with the staff included in appendix 8. It may, however, be necessary to limit in the earlier years the provision of diagnostic facilities to cases of communicable diseases.

44. In order to make the service provided at the hospital as complete as possible we have also included X-ray and dental departments.

45. A secondary unit is normally expected to cover an area with a population of about 600,000. Our proposal to establish a secondary unit in each district simultaneously with the inauguration of the plan seems to require a word of explanation, as the population covered by the scheme in each district will reach only 400,000 by the end of the first five years. Two possible objections that may be advanced are that the administration may be made too heavy at the top and that there will be insufficient work for the staff at the headquarters of the

secondary unit. We may deal with the latter objection first. The scheme, which we are recommending, makes a departure from existing health administration in many directions and we feel that an experiment of this nature will require considerable supervision of the peripheral staff. Further, it has already been shown that different forms of service through imperfectly trained staff, such as schoolmasters and villagers, will have to be organised during the short-term programme. Their training will have to be planned and supervised by the staff at the headquarters of the secondary unit. There will also be a considerable amount of work for the latter in organising the main lines of activity in the primary units. In our opinion the secondary unit organisation will find itself fully occupied with its manifold duties from the very beginning, if the scheme is to be developed on proper lines. If this view of ours is accepted as a reasonably correct estimate of the situation, the first objection will also lose its validity. Moreover the laboratory services, which will be provided at the hospital of the secondary unit for the whole area under its charge, constitute an additional reason for the establishment of the secondary unit simultaneously with the inauguration of the scheme. We hope, however, that 30-bed hospitals serving the primary units will, as soon as possible, be provided with microscopes to facilitate early diagnosis of certain diseases such as malaria.

46. Another secondary unit should be established when the population covered by the scheme exceeds 600,000. In establishing these organisations care must be taken to ensure that, as far as possible, existing administrative demarcations, *e.g.*, the sub-divisions of a district, are adhered to because the functions of the health services will have to be integrated with those of other departments of Government.

#### **Rate of Expansion of the Scheme during the First Ten-years**

47. The following tabular statement indicates how we propose that the programme should be implemented during the first ten years:—

Year	No. of primary units (40,000 population) in a district	Population served	No. of dispensaries in primary units, each having two emergency and two maternity beds	No. of 30-bed hospitals in primary units	No. of secondary units	No. of 200-bed hospitals in secondary units	No. of 500-bed hospitals in secondary units
1st year . . . . .	5	200,000	5	1	1	1	..
2nd year . . . . .	5	200,000	5	1	1	1	..
3rd year . . . . .	5	200,000	5	1	1	1	..
4th year . . . . .	7	280,000	7	2	1	1	..
5th year . . . . .	10	400,000	10	2	1	1	..
6th year . . . . .	13	520,000	13	5	1	1	..
7th year . . . . .	16	640,000	16	7	2	1	1
8th year . . . . .	19	760,000	19	9	2	1	1
9th year . . . . .	22	880,000	22	11	2	1	1
10th year . . . . .	25	1,000,000	25	13	2	1	1

48. This table is only meant to indicate, in a general way, the lines on which expansion may proceed. It may be pointed out that, in every province, except Orissa, there are districts, the populations of which fall short of a million. In some provinces the number of such

districts is more than in others. It is therefore suggested that, when the population of a particular district is covered by the scheme before the ten-year period has elapsed (say, for instance by the 6th or 7th year) the Provincial Government should devote the funds and trained personnel, which will thus become available, to advance the programme in one or more of the densely populated districts. Such expansion may with advantage proceed first in industrial areas.

49. In developing the programme on the lines indicated in the above table it must be remembered that the population covered by the scheme will depend upon the number of districts in individual provinces. For instance, in Madras Presidency, the population at the 1941 census was 48·56 millions and the number of districts 24, while, in the United Provinces the corresponding figures were 55·02 millions and 48 districts. At the end of the first ten years, the population over which the scheme will extend in Madras will be 24 millions. On the other hand the population covered by it in the United Provinces will be 48 millions. In the case of Madras, provision would therefore have been made for a little less than 50 per cent. of the inhabitants while, in the United Provinces, the proportion of population served by the scheme would be much higher. There may also be other divergencies. In the Punjab, for instance, the number of districts is 29 while the population at the 1941 census was 28·42 millions. Therefore, even allowing for some increase in the population by the end of the ten-year period, the scheme, if developed on the lines indicated above, will include within its scope practically the whole population. A proposal which, in its practical application, shows such widely divergent results in different provinces may possibly be open to criticism as laying upon certain provinces, a comparatively heavier burden than upon others. Examples are the Central Provinces, the North-West Frontier Province and Assam which fall within the same category as the Punjab as regards the proposed expansion of the health programme but have much smaller revenues than the latter. We therefore suggest that individual provinces may proceed to implement our proposals on the basis of providing, in each case, for at least half the population by the end of the first ten years (appendix 4). In appendix 5 we have attempted to show how the different provinces may adopt this suggestion in their respective areas. We would, however, deprecate this recommendation of ours being interpreted as a suggestion that the rate of progress in the expansion of the scheme, over as wide an area as possible, should be delayed in those provinces in which the availability of funds and of trained personnel would make more rapid progress possible.

#### **Certain Other Aspects of our Proposals**

50. We shall now proceed to examine certain aspects of the programme in greater detail and to make specific recommendations in respect of them for each of the two quinquennia constituting the ten-year period. In doing so we shall confine ourselves to personal health services. Other recommendations such as those relating to professional education, environmental hygiene and medical research will be dealt with elsewhere, as also the subject of industrial health.

#### **Hospital Provision**

51. Some idea of the provision proposed under our scheme for general medical relief in the eleven Governors' Provinces may be

obtained from appendix 5. A number of dispensaries with four beds in each and of 80-bed and 200-bed hospitals will be established in the provinces during the first five years of the scheme. During the second five-year period the number of 80-bed hospitals will be doubled. Each of these hospitals will thus serve two primary units instead of four. The 200-bed hospitals, attached to the secondary units functioning in the first six years, will be enlarged to include 500-beds and the new secondary units which will be created in the next four years will have their 200-bed hospitals. The anticipated numbers of these institutions are shown below:—

## ELEVEN GOVERNORS' PROVINCES

	No. of dispensaries with four beds in each	No. of 80-bed hospitals	No. of 200-bed hospitals	No. of 500-bed hospitals
End of the first six years . . .	2,293	639	216	Nil
End of the ten-year period . . .	3,905	1,990	216	139

52. The distribution of beds in a 200-bed hospital is shown below:—

	No. of beds
Medical . . . . .	45
Surgical . . . . .	55
Maternity . . . . .	30
Infectious diseases . . . . .	20
Pediatrics . . . . .	15
Malaria . . . . .	10
Tuberculosis . . . . .	10
Mental diseases . . . . .	10
Leprosy . . . . .	5

53. The corresponding numbers of beds in a 500-bed hospital will be approximately two and a half times these figures.

54. For tuberculosis, mental diseases and leprosy separate provision is being suggested in special institutions. Even so, a few beds will have to be included in secondary unit hospitals and these will provide material for teaching and research purposes.

55. The total new provision for hospital beds of all types resulting from the proposals outlined in this note will be 109,725 and 279,820 at the end of the first five and ten years respectively. (See appendix 6). The existing number of beds in British India is somewhere about 78,000 so that the figures for total hospital accommodation at the end of the two periods will become:—

at the end of the first five years . . . . .	182,782 or approximately 183,000
at the end of the first ten years . . . . .	352,820 or approximately 353,000

On the assumption that the average population of British India during the first five years of the programme will be 315 millions and

during the second five years 887.5 millions, the ratio of beds to population will be as follows, if our programme is adhered to:—

*Beds per 1,000 population*

At present	End of five-year programme	End of ten-year programme
0.24	0.55	1.03

The first five years will see an increase of over 100 per cent. and by the end of ten years the provision will have become more than four times the present figure.

**Certain Special Health Services**

56. Our recommendations under individual heads such as malaria, tuberculosis etc., are discussed in detail in the sections dealing with these diseases and therefore only the briefest possible reference is being made here to each of them.

**Malaria**

57. The importance of malaria, as a community problem, necessitates as much concentrated effort for its control as the availability of funds and trained personnel will permit. The general plan that we propose is the creation of an organisation at the headquarters of each province for the administrative control of all malaria operations in the province as a whole, of smaller regional organisations numbering about five in the larger provinces and of a number of malaria control units, each under a medical officer with malaria training, for the active prosecution of anti-malaria measures in the affected areas. The details of the staff suggested for each of these three types of establishments are given in appendix 14. It is recommended that, during the first five years, the headquarters organisation and ten control units should be established in each province and during the second quinquennium 15 more such units and two regional organisations.

**Tuberculosis**

58. Under this head our proposals include the following:—

(a) *Institutional service*

The first five-year period:—

- (1) The creation of a 200-bed tuberculosis hospital for each unit of 10 million population.
- (2) The establishment of a large clinic (to be designated "Main clinic"), with facilities for the training of medical and non-medical tuberculosis personnel, at each of the places where the 200-bed hospital is established.

On the assumption that the population of British India will be about 330 millions by the time the first five years of the programme are completed, the numbers of hospitals and main clinics required will be 33 respectively.

- (3) The creation of clinics of a smaller type at the headquarters of each district in British India; the total number required, after deducting the 33 main clinics, will be 183.

The second five-year period:—

- (1) 33 more 200-bed hospitals.
- (2) 33 more main clinics at the same places where the new hospitals will be located.
- (3) 183 more district clinics.

*(b) Training facilities.*

At present the number of places, where facilities can be developed within a short time for the training of tuberculosis workers, medical and non-medical, is limited to five in British India. It is proposed that these should be supplemented by seven more training centres in the provinces during the first five years of the programme. During the next five years each of the 200-bed hospitals and each of the main clinics in association with it will form a training centre, thus providing 33 additional centres. There will therefore be 45 training centres in all working throughout the second quinquennium. It is also anticipated that, of the 33 new areas where a 200-bed hospital and a main clinic will be established, about 20 may be able to function as training centres during the last two years of the period.

We are advised by a special sub-committee of tuberculosis experts which we appointed that about 13,000 medical men will require special training in tuberculosis in order to meet the needs of the country. As regards public health nurses we have already stated our view that the same nurse should, when visiting the homes of the people, carry out such preventive and curative duties as may be necessary in respect of tuberculosis, maternity and child-welfare, school health and other branches of health activity. It will thus be seen that the number of nurses required to be trained in tuberculosis work will be considerable. A rapid expansion of training facilities has, therefore, been suggested in order to meet this need for large numbers of trained doctors and nurses.

### **Nutrition**

59. We recognise the supreme importance of nutrition in the public health programme. At the same time we realise that the raising of the nutritional status of the community to a desirable level involves the solution of many problems which go beyond the sphere of the health administrator. These include measures directed towards improving agriculture, animal husbandry, fisheries, marketing and food administration and the economic condition of the people, in order to place a balanced and sufficient diet within the reach of the masses in the country. We recommend that the immediate measures to be undertaken in the health sphere should include the creation of nutrition sections in the health departments of Governments and the feeding of children in schools. The latter should be a charge on the budgets of Provincial Education Departments. Details regarding the proposed nutrition section are given in appendix 7.

### **Maternity and Child-Welfare**

60. Provision for maternity and child-welfare work forms an integral and indeed as we have emphasized, a vital part of the district health organisation outlined in this chapter. Each primary unit will be divided into four circles, one of them being associated with the headquarters of the unit. For each Circle the staff concerned with



this branch of health activity will be a public health nurse, a midwife and a trained *dai*. The supervision of this staff will be carried out by the woman medical officer attached to the unit. The provision for institutional service will consist of two maternity beds in the dispensary at the headquarters of each primary unit and six beds for the same purpose in each 30-bed hospital serving a group of such units. In each of these 30-bed hospitals there will also be provision for four cots for children.

At the headquarters of the unit and of each of the remaining three Circles will be established a maternity and child-welfare centre which will form the focus from which the health care of mothers and children will be carried into the homes of the people. The welfare centres will hold a weekly clinic at which as many expectant and nursing mothers, infants and children as can be persuaded to come, will be given medical care, suitable supplementary food and health education. The woman medical officer will conduct the weekly clinic at the headquarters of the primary unit and will visit the other three centres once every fortnight. Alternate clinics in these centres will be conducted by the public health nurse who will carry out certain routine examinations and treatments under the guidance of the woman doctor.

### School Health

61. We have conceived our school health programme on a wide basis, and have therefore considered it necessary to include in it not only the detection and treatment of the child's physical defects, but also the promotion of its general sense of well-being through the provision of better nutrition, through proper physical training and the inculcation of healthy habits. Our scheme provides for the training of two teachers from every school for the carrying out of certain special health duties to be assigned to them.

In order to work out the administrative and technical details of the programme, we have suggested that the scheme should first be developed in the field training centre associated with the medical college at the headquarters of each province, that it should later be extended to the headquarters of the secondary units in each district and, at a still later stage, to the headquarters of each primary unit.

### Dental Service

62. It will not be possible to develop even the beginnings of a dental service during the first five years of the programme because of the total inadequacy of existing dental personnel. If our scheme of dental education should proceed satisfactorily it would be possible to organise dental service on a modest scale during the next five years. Certain proposals for such a service are made below, although it is recognised that they may materialise in complete form only towards the close of the first ten years of the short term programme.

(a) Every 500-bed hospital at secondary unit headquarters (139 in all)—

#### Staff:

Officer-in-charge of Dental Section	1
Orthodontal Surgeon	1
Dentists	3
Dental Hygienists	5

(b) Every 200-bed hospital at secondary unit headquarters (216 in all)—

**Staff:**

Orthodontal Surgeon . . . . .	1
Dentists . . . . .	2
Dental Hygienists . . . . .	4

(c) A mobile dental organisation for each secondary unit—

**Staff:**

Dentist . . . . .	1
Dental Hygienists . . . . .	2
Attendant . . . . .	1

The number of these mobile organisations, at the end of the first ten years, will be 710.

### **Venereal diseases**

63. The formation of an adequate plan for dealing with this problem is complicated by the fact that very little reliable information is available regarding the incidence of these diseases in the community. The development of our health programme and the consequent expansion of treatment facilities as well as special sample surveys by the health authorities are essential before we can get a fairly clear picture of the prevalence of infection in the population. In the meantime the immediate measures to be undertaken should include the following:—

- (1) There should be in every province a Chief Venereal Diseases Officer with a suitable establishment on the staff of the Director of Health Services;
- (2) Each district headquarter hospital should be provided with a clinic on the premises;
- (3) For each secondary unit hospital there should be a provision of Rs. 2,000 per mensem for the purchase of drugs for use at this hospital and at the other hospitals and dispensaries in the area for which it is responsible.

The details of expenditure in connection with these proposals are given in appendix 8.

### **Mental diseases**

64. Our proposals are:—

- (a) the creation of mental health organisations as part of the establishments under the Director General of Health Services at the Centre and of the Provincial Directors of Health Services;
- (b) the improvement of the existing 17 mental hospitals in British India and the establishment of two new institutions during the first five years and of five more during the next five years;
- (c) the provision of facilities for training in mental health work, in India and abroad, for medical men and for ancillary personnel in India; and

(d) the establishment of a Department of Mental Health in the proposed All-India Medical Institute.

The details of expenditure are given in appendix 9.

### Leprosy

65. We have made the following proposals for extending anti-leprosy work in the country:—

- (1) the establishment of a Central Leprosy Institute of India;
- (2) the creation of Provincial Leprosy Organisations;
- (3) increase in the existing provision for institutional treatment, namely, about 14,000 beds by an equal number in the first five years and a similar number in the second five years;
- (4) development of group isolation colonies and
- (5) substantial financial help to voluntary organisations engaged in anti-leprosy work.

Appendix 10 gives the details of expenditure under these heads.

66. The number of doctors and of nurses, required under our scheme, is given below. Details are given in appendices 11 and 12 respectively:—

	First five years.	First ten years
Doctors . . . . .	15,043	29,314
or approximately . . . . .	15,100	29,400
Nurses (including public health nurses) . . . . .	32,510	80,362
or approximately . . . . .	32,600	80,400

67. We propose that the fully trained public health nurse should, as far as possible, replace the health visitor in our organisation. The present day health visitor is imperfectly trained for the duties that a woman worker of this type is expected to perform. At present the courses of training undergone by a health visitor consist of training in midwifery, which extends in different provinces from one year to a year and a half, and special training as a health visitor, which again lasts in different places from nine to eighteen months. The general education standard required also varies from the lower middle school grade to the matriculation. Only a very limited number of persons with training in nursing, enters the schools for health visitors. On the other hand, the public health nurse we propose will have the full nursing qualification, including midwifery, and will, in addition, have been trained in a field training centre so as to develop the community outlook and experience in domiciliary service. It is only through the provision of such a type of woman worker that remedial and preventive health work can be dovetailed into each other and that a domiciliary service, including nursing in connection with the treatment of disease, can be developed. In our long-term programme we have outlined the main features of such a scheme, which we consider essential for an effective campaign against child morbidity and mortality as well as for safeguarding the health of women.

**Numbers of Doctors and Nurses required**

68. We have given above only the figures for the number of doctors and nurses who would be required under the proposals we have outlined. These have been taken as examples to demonstrate the magnitude of the task involved in providing adequate trained personnel for the development programme. As regards doctors, the existing numbers, the figures for those who are expected to be made available under the training programme outlined elsewhere in this report and the numbers required for each of the two periods of expansion under consideration are given below:—

*Number of doctors for British India*

		Graduates	Licentiate	Total
Existing numbers (approximately)		18,200	29,200	47,400
Expected to be made available (approximately)	1st five years	4,565	3,660	8,225
	1st ten years	16,350	5,572	21,922
Numbers required under our proposals (approximately)	1st five years	15,043	...	15,043
	1st ten years	29,314	...	29,314

So far as doctors are concerned the number required can thus be made available for the requirements of our short-term programme.

69. As regards nurses the position is much worse. The relevant figures are given below:—

	Number of nurses for British India	
Existing number (approximately)	7,000	
	During the first five years	During the first ten years
Expected to be made available (approximately)	15,000	52,500
Number required (approximately), including public health nurses	32,600	80,400

70. It will be seen that the numbers required cannot be made available under the training programme that we have recommended. Our proposals require 100 training centres, each taking 50 candidates, for the first period and an additional 100 centres for the next period. We have assumed that at least 75 per cent of the girls who undergo training will complete it successfully and become available for public service. The expected numbers of 15,000 and 52,500 during the first and second terms can only materialise if (1) the first 100 training centres are started at least two years before the health organisation begins to be established (this will ensure four batches of girls with a training of three years being made available during the first five years) and (2) if the remaining 100 centres are established during the first two years of the scheme in order to ensure that the second group of 100 centres will contribute its quota of nurses at the end of the last year of the first quinquennium.

71. In view of the large difference between the number of nurses required and the number available, we suggest that a third set of 100 training centres should begin to function before the third year of the second quinquennium. If the expansion in the training programmes for nurses suggested above can be carried out, 300 centres will provide about 11,250 trained nurses during each year of the third five-year programme. At the end of the first 15 years the number of nurses trained will be about 108,750 while our long-term programme envisages the employment of about 670,000

nurses. Although our training scheme may appear spectacular, it will be seen that the task of raising the number of nurses from the existing figure of about 7,000 to 670,000 will require an even more intensified effort in the subsequent quinquennia.

72. We must, however, sound a note of warning here. Although we have recommended liberal stipends for the trainees in order to attract the proper type of women, we feel that, in many parts of the country, important social changes will have to take place if the numbers required in our calculation are to be forthcoming. This factor introduces an appreciable measure of uncertainty into our estimate of the number that may become available for service.

In these circumstances the employment of smaller numbers than those recommended in the different types of health organisation under our scheme may be inevitable and even the utilisation, in the initial period, of individuals with lower qualifications than those we have contemplated may be necessary.

73. Certain types of health workers such as health assistants and hospital social workers do not exist at present while pharmacists (a more qualified type than the existing compounder) are also practically non-existent. Reference is made to these categories of personnel only to emphasise the importance of starting the training programme well in advance of the establishment of the proposed new health organisation.

74. We have discussed in Chapter XVIII of this report, the subject of training hospital social workers. We consider it essential that a certain number of them should be attached to the hospitals associated with medical colleges to ensure proper undergraduate teaching in preventive medicine and public health. This type of trained worker is, however, non-existent in India today and we anticipate that the organisation of proper training facilities for this class in the country will take the greater part of the first ten years of the programme. In order to establish such training facilities a beginning will have to be made by obtaining a few trained workers in this field from abroad by sending selected candidates from India for training to the United States and the United Kingdom and by developing Schools of Social Studies on the lines of the Tata Institute in Bombay. We anticipate that an appreciable number of hospital social workers is likely to be produced only in the third five year period of our programme.

### **Estimates of Cost**

75. The non-recurring and recurring cost of all our proposals for the short-term programme, including the establishment of the personal health services described here, the creation and maintenance of the facilities for training health personnel which we have recommended and other items of expenditure, are given below separately for the first and second five-year periods of the programme. The figures for recurring expenditure include the cost of maintenance of capital works at 3 per cent per year. In each period the estimated capital expenditure will, it is assumed, be spread evenly over each of the five years. It is on this assumption that the maintenance charges have been calculated. The figures also include provision for repayment of loans to finance non-recurring expenditure. Provision has also been made for a leave reserve of officers and subordinate staff, at the rate of 10 per cent for men and 15 per cent for women.

Total estimated expenditure during first ten years of the programme:—

(In crores of rupees)

	Non-recurring		Recurring			
	First five years	Second five years	First ten years	First five years	Second five years	First ten years
	162·97	200·02	362·99	170·10	331·42	501·52
Amortisation amount	..	..	..	25·76	74·64	100·30
Total recurring expenditure.	..	..	..	195·86	405·96	601·82
Average annual expenditure.	..	..	..	39·17	81·19	60·18

(In millions)

Average estimated population of British India	315	337·5	326·25
	Rs. A. P.	Rs. A. P.	Rs.
Annual per capita expenditure . . .	1 4 0	2 7 0	1 14 0

### District Health Unit

76. In the preceding chapter, we have described the larger controlling organisation at the headquarters of each district. In our ten-year programme we are not recommending its inclusion because we do not consider that it will be essential during this period. The establishment of this organisation should be commenced as soon as the greater part of individual districts becomes covered by the scheme, because, at this stage, coordination of the activities of individual secondary units will become imperative in the interests of efficiency. Such an expansion of the scheme, we anticipate, will take place in the third quinquennium, and the establishment of the controlling organisation at the headquarters may therefore have to be taken in hand at the beginning of this period.

## CERTAIN OTHER POINTS IN CONNECTION WITH OUR PROPOSALS

### Field Surveys

77. We consider that a field survey is highly desirable in association with our programme of health development. Such a survey should cover all the more important facts relevant to the health of the area investigated, including information regarding existing facilities, governmental and other, for medical and preventive health services in the area. Further, as socio-economic factors are of importance in any study of community health, inclusion of information of this nature is also desirable.

It will obviously be impossible for reasons of cost and because of the inadequacy of trained personnel to survey the whole area over which the scheme will be introduced in individual provinces. We suggest that the survey may be confined to the five primary units of each of two or three districts which can be selected as being more or less representative of the conditions prevailing over the province as a whole. The introduction of our programme in the areas concerned, should, however, not be delayed because the survey has not been completed.

We would also suggest that the Central Health Department should draw up a detailed programme for these surveys in order to enable provincial governments to carry out this preliminary study on

a fairly uniform basis. The training of the personnel employed for this purpose in the different provinces should also be uniform as far as possible. This will require that the training for such workers should be limited to a few centres. The All-India Institute of Hygiene and Public Health would be one such suitable centre for training. If, as has been suggested by some of us, Delhi Province is developed as a demonstration centre, it will also provide suitable facilities for the training of the survey personnel. A centre for South India can probably be provided in the Province of Madras through the combined facilities that the King Institute, Guindy, and the Madras Public Health Department can provide.

### **Housing Accommodation for the Health Staff**

78. We consider it essential to provide suitable housing accommodation for the staff of the primary and secondary units and for the staff attached to the hospitals of different types which we have recommended. The total capital expenditure on the provision of accommodation is estimated at 48.10 crores during the first five years and 61.67 crores during the next five years. These are large sums of money but, in our view, the expenditure is fully justified. We consider the provision of accommodation essential in the interests of efficiency. Every health administrator is today faced with the problem of persuading doctors to settle in the villages. The absence in rural areas of the amenities that are generally available in towns, including housing and water-supply, and inadequacy of facilities for educating children are some of the factors retarding the flow of doctors from urban to rural areas. The same tendency is noticeable, though to a smaller extent, in respect of other types of health personnel. In the circumstances we consider that the provision of housing is fundamental to the success of our scheme. Without such provision it will be difficult to keep the staff contented and happy.

79. Nor need the expenditure of public funds on housing for the staff be a drain on the resources of the country. It would certainly be equitable to recover from the occupant a suitable rent which should in any case not exceed 10 per cent of the individual's salary. We think, however, that employees drawing Rs. 50 a month or less should be given free quarters.

### **Cooperation of the Health Services with other Departments of Government**

80. We have already stressed the need for the national programme of reconstruction being developed on a broad front. In fact the advance that can be made in any one section of this front will largely depend on the progress made simultaneously in others. For instance, an improvement in the nutritional status of the people, their education, the spirit of cooperation developed among them will all help to supplement the activities of the Health Department in raising the standard of health of the people. In the circumstances we consider it important that, simultaneously with the inauguration of the health scheme, the reconstruction plans of other Departments of Government should be brought into operation in the same areas.

### **Village Communications.**

81. We must emphasise the vital importance of developing village communications in order to enable the health organisation to offer

efficient service to the people. Without these our whole plan for the rural areas may either be paralysed or lose much of its effectiveness. The staff of a primary unit should, in order to give efficient service, be able to move rapidly to every part of the area covered by the unit while effective supervision, on which depends the success of the scheme, would become impossible unless inspecting officers could visit all parts of their charge easily and frequently. Moreover, the economic life of the rural areas will be quickened by the establishment of closer relations with the towns and the earning capacity of the villager will be raised. The health and welfare of the village population largely depend on the development of rural communications and we would unhesitatingly support the need for giving priority of the highest order to such development, even at the expense of the projected programme of highways throughout the country.

### **Ambulance**

82. The provision of ambulances for the transport of patients is an important factor in the improvement of the efficiency of the health services. For each 30-bed hospital two motor ambulances and one animal drawn ambulance have been provided. These will, however, prove of limited value if village communications remain undeveloped.

### **Travelling Dispensaries**

83. In the more sparsely populated parts of individual provinces it may be found advantageous to provide travelling dispensaries in order to supplement the health services that will be made available to the people through the primary health units. The areas in which these travelling dispensaries should be provided and the extent of such provision are matters which can be settled only in the light of local knowledge and we must therefore leave it to Provincial Governments to work out the details.

The effective functioning of these dispensaries will also require the development of rural communications on the widest possible scale.

### **Utilisation of the Buildings, Equipment and Personnel that will be made available from the Army after the war**

84. The war, with all its attendant evils, may we hope be productive of some beneficial results. The needs of a modern Army have brought into existence a number of health services and the personnel, equipment and buildings connected with these can, in many cases we believe, be advantageously utilised in the development of our health programme. Anti-malaria units, hygiene squads, hospitals constructed for war purposes, military camps, large air fields in different parts of the country with all the necessary amenities such as roads, water-supply and lighting, motor vehicles of various types, should, we suggest, be made available on easy terms for the development of the health programme throughout the country. Certain large camps situated at convenient distances from large cities and connected with them by good roads should prove particularly useful in developing institutions for chronic cases and incurables. Such institutions are, apart from their humanitarian aspect, of special value for the training of medical students. At present, the pressure on beds in existing hospitals is so heavy that



chronic cases have little chance of being retained, as they have to make way for the continuous stream of new patients flowing into these hospitals.

### **Medicinal spas**

85. We understand that there are a number of thermal and other springs in different parts of the country, which are capable of development into medicinal spas. Some of these are centres of religious worship and we believe that their conversion to such use is not possible for many years to come. On the other hand, there are others which have no religious significance attached to them. The possibility of developing these should, in our view, be investigated by the Provincial Governments and by Administrations under the Central Government.

### **Establishment of field training centres in association with training institutions**

86. In the section dealing with professional education we have dealt with the need for providing field training facilities for all types of health workers, medical and non-medical. We propose that the training centre for each college should consist of 15 primary units under the control of a secondary unit. In our view the provision of such training centres can advantageously be made by increasing, in those districts in which medical colleges already exist or will be established, the five primary units proposed for every district at the initial stage of our programme to the required number of fifteen units with the least practicable delay. The establishment of these training fields in association with teaching institutions will thus help to extend the new health services to further sections of the population.

### **Delhi Province to be developed as a Demonstration Area**

87. In the proposals outlined in this chapter we have confined our attention to the eleven Governors' Provinces. Conditions in the Centrally Administered Areas vary greatly so that any proposals put forward on uniform lines will not be applicable to them. The Delhi Province stands by itself among the Centrally Administered Areas and we are giving it detailed consideration in a separate chapter. Some of us are definitely of the view that the Central Government should make this Province a demonstration area by implementing the proposals of the Committee as well as those of other Committees which have put forward schemes for post-war reconstruction. So far as our proposals are concerned, we feel that they make such a departure from existing practice in the fields of health administration and professional education that a demonstration of the way in which our programme can be carried out effectively will be of the greatest value to the Provinces in developing their programmes.

88. As regards the other Centrally Administered Areas we feel that the proposals outlined in this and the previous chapter should provide sufficient material to enable local administrations to develop plans suitable to their individual territories.

### **CERTAIN OBJECTIVES FOR THE THIRD FIVE-YEAR PROGRAMME**

89. We have already stated that it will be difficult to formulate definite plans beyond the first ten-year period. For reasons we have-

already discussed the rate of progress in the proposed expansion of health services is bound to vary in individual provinces. A programme for the succeeding five years must naturally be based on what has been achieved during the preceding period. Any suggestions we may put forward therefore for the third quinquennium can have relevance only as a general guide to Provincial Governments. Due regard will have to be paid to what has been accomplished in individual provinces and the proposals for the third five-year term, which we give below, may in consequence have to be modified. We may emphasise that only certain broad suggestions are being put forward.

### **Third Five-Year Term**

(1) Hospital accommodation to be raised to 2 beds for every one thousand of the population.

At the end of the first ten years our scheme provides for one bed per 1,000 population.

(2) Expansion of the scheme so as to cover three-quarters of the population of individual districts, wherever possible.

(3) The creation of 12 new colleges in addition to the 48 to be established during the first 10 years.

(4) The establishment of a fourth set of 100 training centres for nurses.

(5) The training of 500 hospital social workers.

90. There are two questions which might perhaps be suitably dealt with at this stage. These are:—

(1) Is it wise to save those who are physically unfit, either through inherited disabilities or through faulty development, by interfering with nature's process of elimination?

(2) By reducing morbidity and mortality through a national health programme may we not be aggravating the existing pressure of population on the nation's resources, a pressure which many are genuinely apprehensive has already become too heavy for the country to bear?

91. We recognise that it is not easy to provide complete and satisfying answers to these questions. Nevertheless, we feel that, as the fears and misgivings implicit in them cannot escape the attention of thoughtful men and women, it is incumbent on us to set forth our views.

92. From day to day we are faced, as individuals or as a community, with the necessity for taking decisions in respect of courses of action which are charged with the potentiality of producing results, both good and evil. In taking such decisions our safety seems to lie in following those moral and ethical ideas which mankind has been developing through the ages as the basis of social justice. If we do so we must come to the conclusion that there can be no going back and that we must press forward with our programme of health development, although it must be admitted that we do not see at present how we shall steer clear of certain dangers which appear indistinct but ominous in the distance.

93. In regard to the first question, we may say that, in the experience of countries where community health programmes have functioned for some time, the purposeful saving of lives, which might otherwise have been eliminated, has not, to our knowledge, been accompanied by any recognisable signs of a deterioration of the national health. It is on infant life that environmental and other adverse conditions produce the greatest possible harm and the question under consideration can perhaps be studied best in relation to this section of the population. We may quote here the remarks of Sir Arthur McNalty, a former Chief Medical Officer of the Ministry of Health, England, in his annual report for 1936, as that country is the one with the longest record of national effort for the improvement of the health of the people. He says:—

“In last year's Report, speaking of the difficulty which must confront continuous reduction of the rate of infant mortality, reference was made to the view that, under modern conditions, some weakly children survive the first year who, a generation ago, would have perished soon after birth. That such cases happen and that, in the aggregate, their absolute number may be large, is a proposition which one would have supposed to be indisputable. Nevertheless, some readers have seen in this statement support of the obsolete theory that national vigour is impaired by saving the lives of the “unfit”—i.e., of those who perished under a particular environment. According to the adherents of this doctrine, environmental measures calculated to save the lives of the “unfit” would have the result of decreasing the *average* stamina of survivors and so lowering the resistance of the population at later ages. As Sir Arthur Newholme has frequently pointed out, decline in rates of mortality at ages after infancy has not slackened since infant mortality began to fall. In the Annual Report for 1933 (pp. 17-24) Sir George Newman also drew attention to the enormous improvement in the rates of mortality in early childhood and adolescence. Thus at ages 1-2, 2-3, 3-4 and 4-5, the rate of mortality in 1926-32 was less than one-quarter of the corresponding rate in 1861-70 and less than one-half the rate of 1901-10. Even in the years of adolescence, 15-20, where some slackening in the rate of decline is observed the death rate in 1921-30 was only 39 per cent of that registered in 1861-70. So far then as rates of mortality are to be trusted, it is certain that the spectacular fall of infant mortality within this century has not been associated with any deterioration of mortality rates at later ages. That improvement of the environmental conditions of infancy has been at the expense of later ages, is a proposition unsupported by any evidence.”

94. In Sir Arthur McNalty's view therefore the active pursuit of measures for improving the health of the weakest and most vulnerable section of the community has not resulted in a lowering of the health of the nation. Further, so far as the moral and psychological aspects of the question are concerned, we feel that we shall be justified in

claiming that it is compassion for the sick, the helpless and the weak that will eventually become the bond for welding humanity into one homogeneous whole.

95. It may sometimes happen, as in the case of the poet Keats, that it is the frail body that harbours within it the finest flower of the human spirit. Shall we not be right in demanding that Nature shall not be permitted to eliminate, in her ruthless way, such persons, whose contribution to the sum total of human happiness may prove to be of the highest type?

96. As regards the population problem, we have devoted a special chapter to it and discussed there the possible consequences of large increases in population and certain suggestions for dealing with them.

97. The minute of dissent, which follows this paragraph, is mainly critical and not constructive. It only recommends that there should be "as even a distribution of facilities accruing from increased personnel, accommodation and equipment, as requirements of special institutions, geography and density of population may permit". We consider that such a recommendation is far too nebulous to be of any practical value to health administrations in the country. Further, if it is accepted and acted upon by these administrations, the result may be a congeries of unplanned accretions to the existing organisations for medical relief and preventive health work and we are doubtful whether any appreciable improvement in the public health will be effected. On the other hand we believe we are right in claiming that, in the scheme we have put forward, we are advancing a new conception of health development in the place of the existing system of curative and preventive health services functioning, to a large extent, independently of each other with results which are far from satisfactory. We have recommended a scheme which will, from the beginning, promote the development of remedial and preventive health work on a unified basis as well as provide for an integrated institutional and domiciliary service to the people. In all progressive countries these requirements are considered essential for a modern health organisation. We therefore consider that the acceptance of the recommendation made in the minute of dissent will result in preventing or postponing indefinitely the development of an efficient health service in the country and in securing no adequate return for the large outlay of money and effort involved in the training of health personnel and in the establishment of institutions under the scheme.

We cannot also permit a statement made in the minute of dissent to pass without comment. They say that we have favoured the establishment of the scheme in a limited area, in the first instance, on the following two grounds:—

- (1) That the existing personnel lacks the training to make preventive medicine an integral part of medical relief.
- (2) That zoning of the operation of the proposed system of medical relief is essential for demonstration of expected results.

As regards (1) above, there seems to be no fundamental difference of opinion between them and the rest of us. They have suggested short courses of training for medical men in order to equip them for combined duties in the fields of medical relief and preventive work. From para. 22 of this chapter it will be seen that the

recommendation of the rest of the Committee is the same. The need for such training, if any scheme of health development is to be worked successfully, is therefore accepted by all. But the existing medical personnel with such training, supplemented by those likely to be made available through the training programme of the short-term, cannot possibly suffice to extend the health organisation over the country as a whole. It therefore seems inevitable that a health programme such as the one we recommend must be implemented in stages.

As regards (2) above, we have recommended no zoning of each district into two areas in the sense understood by the writers of the minute of dissent. If the necessary funds and staff are available there is no reason at all why individual Governments should not proceed beyond the programme which we have drawn up as a general guide to the provinces. We have, indeed, recommended such expansion in the last sentence of para. 49 of this chapter.

#### **A Note on Medical Relief by Dr. Vishwanath and Dr. A. H. Butt**

The scheme recommended will split up medical relief into two parts. To start with, the scheme will cater for only one-fifth of the population of each district and eventually may come to serve half of the population. It is supposed to absorb almost all the output of medical personnel from training institutions as well as the great bulk of finances. Almost all the up-to-date buildings, equipment and well-trained personnel will be located in the area of operation of this scheme. During the short-term programme the major part of the country will still be served by the existing organization. Disparity of amenities provided in the two areas, will be too flagrant to escape public notice. Acute discontent and resentment is bound to prevail in the areas left outside the service provided by this short-term scheme.

Concentration of improved facilities in selected regions seems to be favoured on two main grounds:—

- (1) That the existing personnel lacks the training to make preventive medicine an integral part of medical relief.
- (2) That zoning of the operation of the proposed system of medical relief is essential for demonstration of expected results.

We regard these considerations invalid and inappropriate. In our opinion the registered medical profession in India is as well informed, as its counterpart in any other country in the world. Its weakness is mainly quantitative and not qualitative. Its service element can be easily oriented to the performance of combined functions in the fields of Medical Relief and Public Health by attending short courses of instruction organised for the purpose. Instructions so obtained can later on be implemented by directions imparted through circulars, inspecting officers and short visits to headquarters at stated intervals, where later developments in techniques can be demonstrated by higher officers of Medical Relief and Public Health Departments.

As for the value of zoning for demonstrating results, we must state that we are strongly opposed to making any areas or population into experimental units. No system of medical relief or preventive medicine should be applied to the people, the results of

which are not already proved to be beneficent to an eminent degree. This application must be as wide and uniform as the resources of the State in material and personnel permit, at a given time. The existing machinery of medical relief, however, inadequate and unsatisfactory is not ill-suited to furnish the foundations for evenly spread improvements. The scheme proposed by the majority will establish dyarchy of medical administration in each district. Between the existing arrangements which will be operative over the major part of a district and the new on which will be showered all available facilities of personnel and equipment, there is bound to be considerable friction which will react detrimentally on the volume and quality of the social service. We advocate as even a distribution of facilities accruing from increased personnel, accommodation and equipment, as requirements of special institutions, geography and density of population may permit.



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## CHAPTER V

### THE NUTRITION OF THE PEOPLE

#### Introduction

1. In view of the great importance of the subject we considered it necessary to obtain the advice of outstanding nutrition workers in the country before formulating our proposals. The Indian Research Fund Association has a Nutrition Advisory Committee of which the Chairman is the Public Health Commissioner with the Government of India, and the Secretary, the Director of the Nutrition Research Laboratories, Coonoor. The members include most of the important laboratory workers in the subject in different parts of the country, public health officials actively engaged in nutrition work and certain officers of the Government of India such as the Agricultural Commissioner, the Animal Husbandry Commissioner and the Educational Adviser. At our request, this Committee prepared a valuable report on the subject and, in the succeeding paragraphs, we shall freely quote its views.

2. We fully endorse the view of the Committee that the national health campaign is concerned not only with the prevention of disease, but also with the development of a healthy and vigorous population and that improved nutrition plays an important part in preventing sickness as well as in promoting positive health. To quote from its report:

"The modern public health movement is not concerned solely with the prevention of disease. It has the broader aim of creating an environment in which each individual can develop his potentialities fully and completely. This is particularly true as regards nutrition. Malnutrition produces states of ill health and lowered physical efficiency, short of actual disease, which are perhaps more important, because more widespread, than disease itself. Numerous investigations among school children in India have shown that a large percentage of children are in a poor state of nutrition, with consequent impairment of physical and mental growth. Again, in the adult population the ill-effects of malnutrition are widely evident in the shape of a low level of general health and reduced capacity for work. On the other side, the striking improvement in the condition of army recruits which takes place after a few months of abundant and satisfactory feeding, is highly significant.

"The positive aspects of the campaign for improved nutrition must be strongly emphasised. Freedom from disease is one thing, abundant health is another. The goal to be aimed at is the creation of a healthy and vigorous population."

#### **The Nutrition Problem in India**

3. We have discussed, in our review of the subject in the previous volume of the report, the average Indian diet and pointed out its many deficiencies. We may, however, refer to the matter again here briefly. There is reason to believe that both under-nutrition and mal-nutrition exist widely in the country. The daily energy requirements of an adult of either sex, living an ordinary life without manual labour, has been estimated at 2,400 calories to be derived from the food that is assimilated. Those who do mode-

rate work require 2,500 to 2,600 calories, and those who are engaged in occupations involving heavy manual work require about 2,800 to 3,000. In Health Bulletin No. 23, "The Nutritive Value of Indian Foods and the Planning of Satisfactory Diets", (1941), an insufficient and ill-balanced diet giving only 1,750 calories per day is described by Dr. Aykroyd, the Director of the Nutrition Research Laboratories, Coonoor as "typical of diets consumed by millions in India". It is clear that, from the point of view of energy requirements, such a diet is quite insufficient.

4. The quality of a diet depends on its being able to provide certain essential chemical entities in proper proportions. They are (1) carbohydrates, (2) proteins, (3) fats, (4) minerals and (5) vitamins. Carbohydrates form the main energy-yielding element in our diet. Wheat, rice and other cereals form our chief sources of carbohydrates. Sugar is another. Proteins are an essential constituent of our food as they are utilised in building up the body and in replacing tissue waste. They may be of animal or of vegetable origin. Speaking generally, the former are more valuable than the latter. Their "biological value" is said to be high and they are often called first class proteins. Our chief sources of animal protein are milk, eggs, fish and meat, while the pulses constitute important sources of vegetable protein. A certain proportion of the total intake of protein should consist of first class proteins, if the diet is to be considered satisfactory from the nutritional point of view. All over the world, the production of articles of food, providing animal protein for human consumption, is recognised to be more costly than the production of articles containing vegetable proteins. Fats are generally available to us either in the form of ghee or butter, of vegetable oils or of the fat of animals derived from meat and fish. In order to obtain a sufficiency of the different minerals required by the human body, the consumption of a variety of vegetables is necessary. Vitamins are considered essential for the proper utilisation of food and for the satisfactory functioning of the body. While they are found in the different articles of food we consume, laboratory methods of production have more recently been developed in respect of a number of these vitamins.

5. From the point of view of quality, the main defects of the average Indian diet are: an insufficiency of proteins (in respect of both total intake and of first class proteins), of mineral salts and of vitamins. Rice is the staple cereal over large parts of the country, and in the rice-eating areas the consumption of pulses, which provide vegetable proteins and certain vitamins, and of milk, eggs, fish and meat is definitely low. The consumption of vegetables and fruits, is also much below the desirable level. Lastly, the average rice-eater's diet does not include a sufficient quantity of fat of vegetable or animal origin.

6. We shall first deal with the main question of raising the dietary standard of the people, and later make certain recommendations in respect of two closely associated problems, namely, control of (1) the purity and (2) the quality of the food supply of the community.

### **General Measures**

7. The general raising of dietary standards throughout the country is, as pointed out by the Nutrition Committee, basically



"an economic problem, the solution of which is dependent on the scientific development of agriculture, animal husbandry and fisheries, and the simultaneous development of industrial resources. Economic surveys have shown that the poorer sections of the community cannot afford to purchase a nutritionally adequate diet; they have also shown that with rising income the diet becomes more satisfactory and approaches more closely to approved nutritional standards. An increase in the prosperity of the country, associated with a rise in agricultural production, will thus automatically produce a general improvement in nutrition. It is not, however, sufficient to point out that the latter is dependent on, and will follow, a change for the better in economic conditions. Agricultural and economic policies must be established which have as their primary objective the betterment of diet. A food policy is necessary, and this must be firmly based on nutritional science."

8. We suggest that Provincial Governments should place before themselves the objective of meeting their essential food requirements from their own territories to the utmost extent to which this may be possible. The Nutrition Committee points out that "The United Nations Conference on Food and Agriculture (1943) accepted the principle that governments are responsible for introducing general and specific measures for improving the diet of their people. The Conference in addition to making recommendations about the feeding of "vulnerable" groups, the necessity for education on nutrition, etc., broadly outlined the method of approach to food policies designed to improve nutritional standards. Its views may be summarised as follows:—

"The first step, in planning nutritional problems, is to estimate the average consumption of the various foods by the population concerned, preferably on a *per capita* basis. The rough data about food intake so obtained should be checked by family diet surveys. The state of nutrition of the population should be investigated by medical and public health workers. In this way the defects of the national diet will be made manifest. The adjustment of agricultural and economic policy to correct the defects follows.

"On the question of dietary standards, the Conference made the following recommendations:—

"That governments and authorities here represented adopt as the ultimate goal of their food and nutrition policy, dietary standards or allowances based upon scientific assessment of the amount and quality of food, in terms of nutrients which promote health, and distinguish clearly between these standards and the more immediate consumption goals which necessarily must be based upon the practical possibilities of improving the food supply of their populations.

"Because of the inaccuracy of existing food production data, it is impossible to indicate precisely the increase and changes in food production which are necessary to raise the diet of the population to a satisfactory level. Nutrition workers can, however, lay down standards for requirements of the various important foods which can be used as the basis of All-India or provincial food policies.

"The ultimate objective should be the provision of an optimum diet for all, irrespective of income, and plans should be laid to reach the objective by forced march, stage by stage, within a specified period of time. The governmental machinery at the centre and

in the provinces necessary to plan and execute food policies cannot be considered in this report. In view of the inequalities in the production and consumption of various foods in different parts of the country, technical and financial assistance from the centre and co-ordination of provincial effort are obviously desirable. The distribution of food, with the various problems it involves, is as important as its production.

"It is the responsibility of nutrition workers to assess the food requirements of the population on a satisfactory basis. The infinitely more formidable task of fulfilling these requirements lies beyond their sphere of action. It would be outside the scope of this report to discuss the scientific development of agriculture, animal husbandry, fisheries, the mechanisation of farming, irrigation schemes, co-operative societies, consolidation of holdings, the need for the large scale manufacture of fertilisers, rural transport, and other questions of equal importance which bear on the problem of increasing food supply and raising dietary levels. Close contact between nutrition workers and those concerned with food production in its various aspects is, however, vitally necessary, if food planning is to be developed along satisfactory lines. Special emphasis may be placed on contact between nutrition and agriculture, animal husbandry and fisheries. Nutritional advice is required in connection with crop-planning, the production of new varieties of seed, and numerous other matters. The activities of central and provincial food administrations, both during the present period of food shortage, price control and rationing and in the future when progressive plans are being developed, should be guided by advice and assistance from nutrition workers.

### **Specific Measures for Improving Nutrition**

"(A) *Nutrition work in Public Health Departments.*—Public health nutrition work is as important as other activities of public health departments, such as the prevention of epidemics, the disposal of sewage, etc. It follows that health organisations must be extended so as to include work in the field of nutrition among their recognised functions.

"(a) *Nutrition work in the Central Health Department.*—The Central Public Health Department should include a highly trained nutrition specialist with wide experience of the public health aspects of the subject. The specialist will be on the one hand in touch with experts in other branches of public health in the Central Health Department and on the other with the central nutrition research organisation, provincial nutrition sections, and research workers in the nutritional field. He should advise the Central Government on nutritional policy through the Director General of Health Services.

"(b) *Nutrition sections of Provincial and State Public Health Departments.*—The section should be in charge of a nutrition officer of the rank and status of an Assistant Director of Health Services with a suitable staff. The staff required will depend on the size and population of the province, the extent of the problem of malnutrition, etc. The training and qualifications of public health nutrition workers will be considered later. The section should include a properly equipped and staffed laboratory. The following are among its important duties and functions:—

- (i) Study of the composition of foods of local importance.
- (ii) Diet surveys.

- (iii) Investigations of the incidence of malnutrition and deficiency disease and of any public health problems associated with nutrition which may arise.
- (iv) Apart from these special lines of research, nutrition research generally may be included among the functions of the nutrition section.
- (v) The section must pay special attention to the nutrition of 'vulnerable' groups, *e.g.*, infants, children, expectant and nursing mothers and students. It should work in association with such branches of public health as maternity and child-welfare and school medical inspection. The nutrition of industrial groups is also a question of great importance.
- (vi) The section should serve as an information bureau on nutrition for the benefit of other departments and the general public, and be responsible for providing material for education and propaganda. It should advise about diet in public and private institutions.
- (vii) Nutrition sections should be in close contact with food departments, educational departments, and agricultural, animal husbandry, fisheries and marketing departments. They should coordinate work sponsored by local bodies and private organisations.
- (viii) A suitable duty of the nutrition officer will be to act as Secretary of the Provincial Nutrition Committee, referred to below. He must also maintain contact with nutrition research institutes in order to keep in touch with advancing research.

"In the public health departments of large municipalities nutrition work should be developed along similar lines, though no doubt on a smaller scale.

"While special emphasis is placed on the employment of specialised nutrition officers in public health departments and on the creation of nutrition sections, it is equally necessary that all public health workers should have a sound knowledge of nutrition. To this end their training must include satisfactory instruction on the subject. This is particularly important in the case of health workers at the periphery, *e.g.*, health visitors, health inspectors, etc., who are in direct contact with the people.

"(B) *Provincial Nutrition Committees*.—These committees, should include experts in nutritional science, agriculture, animal husbandry, fisheries, marketing, food administration, economics, etc., and advise governments on questions which concern the nutrition of the population. While their work should be essentially technical in nature, they may also include purely administrative officers, with the object of securing co-operation in their activities from the administrative side.

"(C) *Deficiency diseases*.—The prevention of deficiency diseases is an important responsibility of public health nutrition sections. Deficiency diseases tend to disappear with a rise in the standard of living and a general improvement in diet, but it is not necessary to await such developments before launching the attack.

"Specific methods can often be effectively used. For example, beriberi may be prevented by the distribution of pure vitamin B<sub>1</sub>, or by popularising the consumption of certain kinds of rice, osteomalacia by the use of vitamin D or by changes in social habits involving greater exposure to sunshine, and goitre by the use of iodised salt. Each deficiency disease presents a specific problem of prevention and the most feasible and effective methods of approach can be discovered only by trial of different methods in various areas and groups. For the development and application of satisfactory preventive measures active public health nutrition sections are essential.

"(D) *The nutrition of expectant and nursing mothers and infants.*—These groups are specially vulnerable to the ill effects of malnutrition. If a child is to get a good start in life, its mother must be properly nourished, and it must itself receive a satisfactory diet during infancy and early childhood. Special attention must, therefore, be given to the needs of mothers and infants. In various Western countries measures are taken to supply additional nutritious food to expectant and nursing mothers of the proper classes and to provide cow's milk to infants for whom breast milk is not available at all or not available in sufficient quantities. It is the responsibility of public health departments, through maternity and child welfare services, to supervise the feeding of mothers and infants. The further development of such services, with special reference to nutritional activities, is much to be recommended. The approach to the nutritional problems with which they have to deal, and ways and means of making work on this field more effective, require more careful consideration than they have yet received and study of these questions will be among the most important activities of public health nutrition sections. In a later section of the report it is pointed out that expectant and nursing mothers and infants should have prior claims in the distribution of milk supplies.

"(E) *Community Feeding.*—(1) *School-feeding.*—The development on a wide scale of school-feeding schemes is recommended by us elsewhere. This, as experience in other countries shows, would be of the greatest value in the attack on malnutrition and would give abundant returns for money spent in the shape of an improvement in the health of the rising generation.

"Ideally, school-feeding should include the provision of a suitable quantity of whole milk. But in view of the fact that whole milk is scarce and dear in most parts of India, recourse may be had to other foods. These include skimmed milk and sprouted pulses. Almost any wholesome food which supplies additional calories to under-nourished children is of value. At the same time, it must be recognised that as far as possible food or meals supplied in school should be such that they help to correct the defects in the home diet. If properly organised on this basis, school feeding may be of genuine value in educating children about nutrition and the importance of a well-balanced diet.

"School-feeding schemes should be organised by government and local authorities with the co-operation and advice of nutrition sections in public health departments.

"(2) *Institutional feeding.*—The satisfactory feeding of children in institutions is a simpler problem than supplying meals to day-school children, but it is one to which insufficient care and attention is often given by the authorities concerned. All children in boarding

schools, orphanages, etc., whether these are under state or private management, should receive an adequate and well-balanced diet. It has already been pointed out that the duties of public health nutrition sections include the giving of advice about feeding in residential institutions, *e.g.*, students' hostels, goals, reformatories, etc., as well as institutions for children.

“(3) *The feeding of employees and labour groups.*—In Europe and America great attention has been given to the diet of industrial workers, particularly during the war. At an Industrial Conference in Great Britain in 1943 it was recommended that the war-time measure of providing a balanced meal to industrial workers should be continued when the war is over. This is a question of importance in India, particularly in view of the fact that industry is now expanding rapidly. The establishment by industrial concerns of canteens supplying good food at low cost is to be recommended. In this connection mention should also be made of labourers on plantations and the secretarial staffs of large business houses. The need for improving the nutrition of workers must be impressed on all employers of labour. The furthering of such developments will be the combined responsibility of governments and employers, but stress may be laid in obtaining the advice of the health department.

“The extension of industrial canteens, etc., is eminently desirable in connection with existing food and rationing policy, and in full conformity with that policy. It facilitates food distribution and helps to satisfy the special food requirements of manual workers.”

The Government of India, which is probably the largest employer of labour in the country, may well set an example in this matter for others to follow.

“(4) *The feeding of other groups.*—The provision of meals in common to large groups has the advantage of reducing wastage of food and consumption of fuel for cooking, with consequent reduction in cost. If organised on sound dietetic principles, it promotes good nutrition. During recent years the large scale community feeding of urban groups has been developed in Russia. The possibility of similar developments in the future in India, and the advantages referred to above, should be borne in mind. In the case of certain groups, *e.g.*, students in cities, properly organised communal feeding at reasonable cost is definitely to be recommended from the standpoint of nutrition.

“(5) *Catering and nutrition.*—The provision of cheap well-balanced meals through agencies which supply food to the general population, *e.g.*, eating houses, hotels, etc., is of importance as part of the general campaign for raising levels of nutrition and would also be of considerable value. It would involve the education of those concerned in catering. Municipal health authorities, which exercise control over catering establishments, of various kinds through licences, should do something to further such developments.

“(F) *Training and propaganda.*—This subject may be considered under various heads; (a) the education of specialised nutrition workers, (b) the education of those who will be in a position to educate the public or engaged in work in which knowledge of nutrition is of value and (c) the education of the general public.

“(a) (i) The question of the education and training of nutrition research workers overlaps with that of the education and training of

workers in other fields of medical and scientific research. It will not be considered here as we are concerned with other aspects of the subject of nutrition. It may, however, be pointed out, that active nutrition research, which implies a body of trained nutrition research workers, is necessary for progress.

“(ii) Specialised public health nutrition workers should receive some training in research methods as well as a good grounding in nutritional science, both in the field and the laboratory. They should have, at least, a year's training in an institution devoted to nutrition research and other branches of the subject. Some knowledge of statistical methods is desirable. They must also have experience of public health work in general, and in particular experience of health work in rural areas, to enable them to deal effectively with nutrition problems in the field.

“(iii) In the United States and other countries large hospitals employ dietitians, whose duty it is to organise and superintend the dietary treatment of patients under the supervision of the medical staff and to ensure that patients receive the best possible diet during their stay in hospital. In India, no developments in this direction have as yet taken place, although existing dietary arrangements in hospitals are often unsatisfactory and more could be done to hasten the recovery of patients, who are suffering from nutritional diseases. Moreover, hospitals provide abundant opportunity for nutritional research on a variety of clinical conditions.

“All large hospitals should employ a trained dietitian with high qualifications. Apart from highly trained specialists, two possibilities present themselves with regard to the training of workers to supervise dietary arrangements and treatment; (i) special courses on dietetics may be arranged for selected nursing sisters and (ii) graduates of domestic science courses who have taken a course in nutrition may be employed as dietitians after receiving a training in nursing. The Domestic Science course in Madras University now includes a course in nutrition for candidates wishing to specialise in this subject.

“In the training of nurses in general, more attention should be given to nutrition. This would help to improve the nutritional treatment of patients in small hospitals which cannot employ a full time dietitian.

“(b) (i) The medical profession has abundant opportunity of assisting in the attack on malnutrition and furthering the education of the public. At present, in the teaching of medical students, the importance of diet in the causation of disease is not, however, given sufficient prominence. The orientation of medical studies, so that greater emphasis is laid on nutrition is necessary. So much disease in India is associated with nutritional factors that there would be every advantage in establishing professorships in nutrition in medical colleges. This would promote research on the prevention and treatment of nutritional diseases and broaden medical education in the desired direction.

“(ii) Other professional groups which can play a part in the campaign against malnutrition include administrative officers in general, officers in food departments, school teachers and inspectors of schools, social and economic workers, workers in agriculture and animal husbandry departments, etc. Instruction about nutrition should form part of the normal training of such workers, its amount and kind naturally varying in the different professional groups in

question. A necessary preliminary is the education of instructors. It is suggested that special brief courses on nutrition should be given by nutrition research institutes and organisations to professors and teachers of various subjects interrelated with nutrition. Special emphasis may be placed on the instruction of teachers in teachers' training colleges.

"(c) All children should be taught simple facts about food and diet, as part of health education. It is the responsibility of central and provincial nutritional organisations to provide the necessary educational material and that of educational departments to impart it to children in suitable form. Attractive booklets, etc., written in English and the important Indian languages, should be prepared. The suggestion is made that in order to ensure the accuracy of educational material on nutrition provincial nutrition officers should be co-opted on text book committees. Reference has already been made to the educational value of school feeding.

"The importance of the education of the public in general cannot be too strongly stressed. Numerous methods can be followed. These include pamphlets, posters, bulletins, press articles, films, wireless talks, demonstrations, exhibits and museums. Instruction about nutrition should be included in adult educational courses. Here again nutritional and health education in general overlap. Provincial and state nutrition departments have an important part to play in developing educational and propaganda work among the adult population. Public health workers, in direct contact with the people, e.g., health visitors, can render valuable assistance in the educational campaign.

"Local nutrition committees which include public spirited and influential citizens can further the efforts of provincial, state and municipal health departments to teach the people satisfactory dietary habits and spread knowledge of nutrition.

"(G) *Assistance from nutrition research institutes and workers.*—The development of the practical and public health aspects of nutrition must be largely the responsibility of public health nutrition sections. But nutrition research institutes and nutrition research workers in university departments, medical colleges, agricultural and veterinary research institutes, etc., have also an essential part to play. They must supply knowledge, guidance, and advice to ensure that full use is made of scientific discoveries and in general ensure that progress takes place along the right lines."

9. These recommendations of the Nutrition Advisory Committee cover a wide field. We fully endorse and recommend them for the earnest consideration of the authorities concerned, Central and Provincial.

#### CERTAIN OTHER MATTERS

##### (1) **Special measures to increase the production of certain articles of Food:**

##### **Proteins**

10. The average Indian diet is inadequate in respect of the quality and quantity of the protein consumed and one of the most difficult problems is that of raising protein consumption to the required level. Proteins of high biological value are of animal origin and, while figures for the consumption of meat, fish and eggs for this country are not available, it is known that the amount of these

articles eaten by the people is very low as compared with other countries. Their relatively high cost places them beyond the means of large sections of the population, particularly for daily use. Further, for certain sections of the community, they are of little or no dietary significance, and milk is the only important source of animal protein. The estimated consumption of milk is less than six ounces per head per day in the country.

11. While vitamin deficiencies of a pronounced character manifest themselves in various forms of disease, protein deficiency generally fails to declare itself as a specific departure from health which can be detected by the clinician. It produces, at the same time, profound effects on the individual by a retardation of growth, lowered vitality and poor muscular efficiency. Further, while most of the vitamins can now be produced in the laboratory and the quantities required for daily consumption are very small, the solution of the problem of increasing protein consumption to the necessary level is much more difficult, as it involves such matters as an improvement of the breeding of live-stock, the raising of fodder crops, the development of the fish industry and, above all, a gradual change in the social habits of many sections of the community to whom the use of meat, fish and eggs is forbidden by custom and religion. A raising of the level of protein consumption is, therefore, more difficult than the provision of adequate supplies of vitamins for the community.

12. We shall deal here with three articles of food which are of primary importance from the point of view of increasing protein consumption, namely, (a) milk, (b) fish and (c) food yeast.

13. (a) *Milk*.—Milk contains proteins of high biological value and, for this reason, its consumption by children and expectant and nursing mothers is to be particularly encouraged. Further, as has already been pointed out, milk is perhaps the one article of food which can be used by all classes of the population in the country in order to increase protein consumption. The need for the use of milk and milk products as widely as possible is, therefore, apparent. The *per capita* consumption of milk in India is, however, much smaller than that of any other country for which statistics are available. The following figures are quoted from a "Report on the Marketing of Milk in India and Burma" (1943) issued by the Agricultural Marketing Department of the Government of India, which gives a broad survey of milk production and distribution in the country.

Total consumption of milk and milk products per head per day.

	Ounces
Canada . . . . .	56·8
New Zealand . . . . .	55·6
Switzerland . . . . .	49·2
Finland . . . . .	45·4
Australia . . . . .	44·4
The Netherlands . . . . .	44·2
Norway . . . . .	41·7
Great Britain . . . . .	40·7
Denmark . . . . .	40·3
U S. A. . . . .	35·6
Germany . . . . .	35·0
Belgium . . . . .	33·0
France . . . . .	30·4
Czechoslovakia . . . . .	26·3
Austria . . . . .	18·8
Italy . . . . .	10·1
India. . . . .	5·8



14. For individual provinces the average rate of consumption varies considerably. Sind and the Punjab top the list with 18 ozs. and 15.2 ozs. per head per day, respectively, and Assam records the lowest average of 1.3 ozs. only. In the Province of Madras, in spite of low production, it is stated that large quantities of ghee are exported to other parts of the country, with the result that the *per capita* consumption of milk and milk products is 3.3 ozs. per day.

15. The present unsatisfactory state of milk production in India is emphasised by the fact that, while according to the 1940 cattle-census India and Burma together possessed about a third of the world's recorded number of cattle or as many milch cattle as Europe, including Russia, the actual production of milk in this country is only about a fifth of that of Europe. On the other hand, Canada, with only about 6 per cent. of the cattle in India is able to produce as much as 25 per cent. of India's milk output.

16. The problem of increasing the consumption of milk is two-fold. Its production must be raised considerably and its price brought down sufficiently low to be within the income levels of the poorer sections of the population. The associated problems cover a wide field of co-ordinated effort in which private enterprise and various departments of Government, such as Agriculture, Veterinary, Forest, Public Health and Co-operative Departments, must take part. A consideration of these problems goes clearly beyond the scope of our report, but we may draw attention to two points mentioned in the Agricultural Marketing Department's report referred to above. With better feeding and management of India's present population of ill-fed cattle it will be possible to increase the output of milk by at least 50 per cent. Secondly, goats of certain breed give as much milk as many types of cattle while the initial cost in respect of goats is comparatively small.

17. We may now consider what would be a reasonable estimate of India's requirements of milk production. Dr. Aykroyd has suggested the inclusion of 8 ozs. of milk per day in the average Indian diet in order to improve its quality. This figure is definitely lower than the 1,000 grammes or about 33.8 ozs. of milk, recommended for expectant and nursing mothers and for children up to 14 years of age, in the Report of the Technical Commission on Nutrition of the League of Nations (1936). That Commission also recommends about the same high rate of consumption of milk by persons at older ages, although it is suggested that some portion of it may be replaced by cheese. In the countries for which figures of milk consumption were quoted in an earlier paragraph, the amount of milk taken in liquid form alone varies from 36.7 ounces per head per day in Finland to 7.5 in Belgium. The only country, in which the figure is much lower, is Italy with its average rate of 2.8 ozs. In these circumstances, it does not seem to be an extravagant estimate if the figure of 8 ozs. of milk per day per head of the population in this country is suggested for consumption in liquid form alone. The present annual production of milk in India is stated to be about 7,447 lakh maunds. This amount will have to be raised by about 38 per cent. in order to meet the demand for liquid consumption alone.

18. The figure of 5.8 ozs. per day, which was quoted earlier from the Agricultural Marketing Department's Report, as the average rate of consumption in India includes milk consumed in liquid form as

well as milk products expressed as equivalent amounts of milk. In India, only about 28 per cent. of the total milk produced is consumed in liquid form, while 57 per cent. is utilised for conversion into *ghee* and the remaining 15 per cent. into other products, such as *khoa*, *curds*, butter-milk and cheese. Taking, therefore, into consideration the existing demand for milk products the total increase in milk production will have to be at least 110 per cent.

19. While a consideration of the detailed measures for the enhanced production and equitable distribution of milk is clearly beyond the scope of this report, we wish to point out that our proposals for specific health services for mothers and children and for the school-going population will largely fail to produce the desired results, unless milk can be made available to these sections of the community as a supplementary article of food, irrespective of the individual's ability to pay for it. It has been brought to our notice that, very recently, the production of synthetic milk, which is claimed to have the same nutritive value as natural milk, has been developed on a laboratory scale in Great Britain. In view of the importance of the milk problem in India, we desire to bring this matter to the notice of the authorities concerned and to emphasise the need for immediate investigation into the claims put forward on behalf of synthetic milk and for promoting its production in India on a large scale, if these claims are justified.

20. (b) *Fish*.—The importance of fish as an article of diet for increasing the consumption of proteins cannot be over-emphasised. India's long coast-line, her numerous rivers, lakes and tanks afford great opportunities for developing the fish industry. The Royal Commission on Agriculture stated many years ago that "fish forms a specially valuable addition to a diet, the staple of which is rice." It went on to point out that improvement in the cultivator's diet holds out much promise of improvement in his general health and the addition of fish to his diet was emphasised as likely to be the most effective method of helping to provide a balanced diet over large areas of the country. Some idea of the inadequacy of the supplies of fish that are at present available may be gained from certain figures for Bengal which Dr. Sunderlal Hora, Fisheries Adviser to the Government of Bengal, gave in a paper read at the Food and Nutrition Conference held in Delhi in January 1944. For that province, where 90 per cent of the people eat fish, an estimate of  $9\frac{1}{4}$  crore maunds of fish per annum is made as the probable total requirement, on the basis of 50 grammes of first class protein per head per day. As against this, the total production of fish in the whole of India, both fresh water and marine, is less than two crores of maunds, of which Bengal produces only half a crore. These figures should help to give some idea as to the extent to which the fish industry will have to be developed to meet the needs of the country.

21. (c) *Food Yeast*.—The Nutrition Committee's report has drawn attention to the necessity for the development of the production of food yeast for supplementing protein consumption in India. Their remarks are quoted below:

"Mention must also be made of the manufacture of dried yeast and yeast extracts, by the growth of yeast in molasses solution. Yeast is of value as a supplement to poor Indian diets, because of

its richness in protein and vitamins of the B group. It has considerable therapeutic uses in the treatment of malnutrition and deficiency diseases. Certain strains of yeast can be grown on molasses to produce palatable products of high nutritive value. In the process, protein and vitamins are synthesised from relatively valueless carbohydrate product—molasses—of which a surplus normally exists in India. The possibility of developing the production of food yeast at low cost should be fully explored."

22. It has been brought to our notice by Dr. G. Sankaran, Professor of Biochemistry and Nutrition, All-India Institute of Hygiene and Public Health, Calcutta, that the Board of Scientific and Industrial Research at Teddington, England, has worked out details of the culture and methods of production of food yeast and that large-scale production has been started in the British West Indies, where enormous quantities of molasses are available. We strongly recommend the immediate investigation of the possibility of producing food yeast on a large scale in India.

### **Urea**

23. Another suggestion, made to us by Professor Sankaran, is the production of urea and its utilisation as cattle food in order to promote the production of meat for human consumption. We give it below in his own words:—

"For long we have been obliged to obtain our animal proteins such as meat and milk through a process of feeding natural foods to other animals. This is a costly and uneconomical process. Very recently a discovery of first rate importance has been made which is as striking as synthetic fertilisers are in plant nutrition. It has been shown that urea, a simple chemical which can be produced in abundant quantities at a low cost, when fed to ruminants, is converted largely into proteins of the animal body. The story of this discovery is interesting. A few years before the present war, Du Pont de Nemours, the biggest chemical concern in America, developed a process of producing urea so very cheaply that its disposal became a difficult problem. Generous grants were made to scientists to find avenues for the extended use of this chemical. One of the American Universities, almost by an accident, discovered its value as a feed for ruminants. This has been extensively corroborated in America and Europe as well as in India. When it is realised that India has the largest cattle population in any single country in the world and that these animals are competing with man for food when a sufficient amount is not available for even human consumption, the value of large scale production of urea becomes apparent. Urea is made from ammonia and carbon dioxide. These two become available in the process of manufacture of synthetic nitrogenous fertilizers. It is thus possible to link such production of cattle food with plant foods."

We strongly urge that this suggestion should be carefully investigated without delay.

### **Vitamins**

24. Vitamins are found in the articles forming the normal constituents of our food. Therefore, if our diet is sufficiently varied in its composition, all the necessary vitamins are likely to be included.

But, as has already been pointed out, the average Indian diet is deficient in vegetables and fruits which supply some of these vitamins, while the use of highly polished milled rice or of bread made of white flour similarly deprives the individual of certain other important vitamins. Milk and eggs contain relatively large amounts of two other vitamins, and the fact that only a very small section of the population can afford their use in adequate amounts results in a deficiency of these vitamins in the diet of large sections of the people.

25. There have been remarkable developments recently in the production of synthetic vitamins. Many of them are now being produced on a large scale in laboratories and in factories. During the present War their incorporation in the staple foods has been carried out in England and the United States of America with great benefit to the health of the people. In the United States of America, it is known that, although their production in the laboratory started only a few years ago, synthetic vitamins are now being manufactured in such large quantities that they are available to the people at a relatively small cost. Dr. Sankaran has stated that, in 1942, an adult could purchase in that country his daily requirement of all the vitamins at about one anna.

26. While some of the vitamins can be synthesised in the laboratory, an important one among them, vitamin A, is non-existent in the vegetable kingdom and has not so far been produced in the laboratory. It is found in appreciable amounts in the oils extracted from the livers of certain species of fish. During the War, when the shortage of cod-liver oil, which is rich in this vitamin, became acute, it was demonstrated that shark liver oil is rich in vitamins A & D and its production has been developed, on a small scale, during the past few years. This industry deserves protection and vigorous development. Hand in hand with such development the strictest control over the quality of the product sold to the public is essential, in order to obviate its gross adulteration which, we understand, is now going on.

27. Another advance in connection with vitamins from these fish oils is that, by the process of molecular distillation under low pressure, the vitamins have been separated from other constituents of the fish oils, which give them their bad taste and smell, and have been obtained in highly concentrated form so that the administration of a very small amount is sufficient to meet the daily requirement of the individual.

28. For large sections of the population, vitamins derived from fish oils may prove to be unacceptable. For them there is an abundant source of vitamin A in carotene which is present in very large quantities in certain types of grass and leaves. For instance, it has been shown that water hyacinth is an abundant source of carotene and its production from this plant has already been demonstrated in the laboratory in this country. Carotene when taken is converted by the human body into vitamin A. The production of carotene in sufficient quantities will make it possible to incorporate it in vegetable oils and hydrogenated fats which are largely used by the people.

29. We recommend that the possibility of developing the production of the different vitamins, on the lines indicated above, should be investigated.

**(2) The Storage, Transport and Distribution of Food**

30. With an increased production of food, provision must simultaneously be made for its storage, transport and distribution. We have already referred to the lack of transport facilities for milk produced in rural areas. All perishable articles of food such as milk, fish and fruit require the development of refrigeration facilities for storage and transport. Without such development even the limited quantities now produced cannot be utilised to the fullest advantage.

31. There is also another aspect of the problem of storing food. Many years ago Colonel Sir Alexander Russell, who was then the Director of Public Health, Madras, calculated that rats alone were responsible for the destruction, each year, of food-grains to the extent of about Rs. 2-18-0 per head of the population. If this estimate is even approximately correct and if the destruction caused by other pests is also taken into account, the extent of the loss of valuable food that the country suffers must be enormous. The need for conserving all the available supplies through proper means of storage and the control of insect and other pests is, therefore, apparent.

**Processed Foods**

32. Food-processing is as yet in an undeveloped state in this country, although there are obvious advantages to be gained both by the consumer and producer by the development of this industry. Perishable fruit, for instance, can, by canning or by conversion into jam, be made available to a large section of the community, and waste as a result of inaccessibility to markets avoided.

33. During the war various methods such as the dehydration of vegetables, fish, meat, eggs and dairy products and the concentration of nutriment from fruit juices through expression, desiccation, solvent extraction and high vacuum molecular distillation were developed in the more important countries involved in the War, in order to utilise to the fullest extent the available supplies of food. In India, similar developments took place only on a small scale in connection with the organisation of food supply to the Defence Forces. The desirability of processing perishable foodstuffs during local and seasonal gluts is such that the possibility of developing the industry should, in our view, be investigated as a part of the campaign for the improvement of nutrition in the post-war period. Such developments will be of the greatest value in connection with milk and milk products, fruits and vegetables.

34. It may not be out of place here to refer briefly to the Food Inspectorate which, it is understood, has been developed during the War for the purpose of ensuring that food for the troops in India is wholesome and is of the necessary nutritive quality. One of the activities of this organisation is the control of processed food produced in India. The duties include pest control in storage depots, mills and contractors' godowns, the hygiene of producing factories, the technical control of manufacture in certain limited spheres, the investigation into the bacteriology of indigenously manufactured food-stuffs and the formulation of processing instructions for certain manufactured articles.

35. We hope that food processing will develop in this country in the post-war period as a part of the programme for improving the nutrition of the civil population. The possibility of securing, as far as possible, the laboratories and the technical staff of this food inspectorate to serve the needs of the civil population should be investigated before they are dispersed. In addition to work in connection with food processing, some of the laboratories could, if suitably situated, serve the needs of individual Provincial Governments in the development of their services for the control of food adulteration.

### **Prevention of Food Adulteration**

36. This subject was considered in great detail by a committee appointed by the Central Advisory Board of Health, and recommendations covering a wide field have been put forward for suitable action by Provincial Governments in the country. We fully endorse these recommendations, the more important of which are mentioned below:

(1) In order to assist Provincial Governments to develop and improve their existing organisation for the detection of food adulteration, it was suggested that the Government of India should appoint a standing Central Committee for Food Standards. Its functions would include (i) the preparation of "Instructions for Public Analysts" to be periodically modified and supplemented in the light of new knowledge and (ii) the laying down of analytical technique for the purpose of ensuring uniformity in food analysis throughout the country.

We understand that this committee has already been appointed by the Government of India on a temporary basis. We think that a technical committee of this nature should function permanently if the purposes for which it is established are to be achieved. We, therefore, recommend its continuance as a permanent organisation.

(2) The creation of a provincial cadre of analysts and the establishment of food laboratories in association with central and regional bacteriological laboratories in individual provinces were recommended.

It will be remembered that, in the chapter dealing with our recommendations for the improvement of medical research in this country, we have described a scheme for the establishment of a regional laboratory service in the province of Madras and have suggested the development of similar services in other provinces also. Control of the purity of food will require not only chemical but bacteriological methods of examination and we, therefore, consider the establishment of food laboratories, in close association with the proposed central and regional bacteriological laboratories in the provinces, a distinct advantage.

(3) In view of the existing low level of health administration in local areas, the Food Adulteration Committee suggested that the provincial Director of Public Health and local Health Officers should be given certain powers which have been vested in them in Madras by the Public Health Act of 1939. We have also included, among our recommendations, for the improvement of local health administration, the conferment of these powers on health authorities in all the provinces.

(4) The Food Adulteration Committee drew attention to the desirability of deterrent punishment in respect of offences under the Provincial Food Adulteration Acts and desired that, in the case of repeated offences, provision should be made for the award of imprisonment.

(5) It was pointed out that, instead of legislating only for the control of food adulteration, it would be desirable to enact on a wider basis so as to bring together all the existing food legislation at present scattered in various Acts. It was also suggested that the existing legislation should be modernised and the law relating to food standardised under an Act of the Central Legislature.

(6) Simultaneously with the provision of adequate legal powers, it was recommended that administrative action in respect of certain essential foodstuffs should be developed through the promotion of co-operative effort for increasing production and for reducing the cost of distribution to the public.

### **Improvement of the Quality of Food**

37. The Agricultural Produce Grading and Marking Act, 1937, which is a Central Act, is intended to secure an improvement in the quality of agricultural produce. It lays down a system whereby different articles are graded and marked according to certain prescribed standards of quality. The prescribed designation mark is known as the "Agmark" and has three grades of quality indicated by different colours. The grade designations are 'Special' (white), 'A' (red) and 'B' (blue). The articles to which such grading and marking apply include fruit, vegetables, eggs, dairy produce, tobacco, coffee, hides and skins, fruit products, atta, oil-seeds, vegetable oils (including hydrogenated oils and vegetable fats), cotton, rice, lac and wheat.

38. The Agricultural Marketing Adviser to the Government of India is entrusted with the working of this Act. Any person or body of persons desirous of being authorised to mark any article with a grade designation mark must apply to this officer who, after due enquiry and after satisfying himself that the necessary conditions are fulfilled, shall grant a certificate of authorisation enabling the person concerned to apply the grade designation mark authorised in the certificate to the articles and at the premises mentioned in that certificate. The Agricultural Marketing Adviser or any person, authorised by him or by the Central Government, has the right of entry to, and inspection of, the premises at all reasonable hours as well as of taking samples for examination. There is also provision for the cancellation, modification, suspension or revocation of the certificate of authorisation after the party concerned had been given 14 days' notice and an opportunity to show cause why the certificate should not be cancelled, revoked, modified or suspended.

39. We are of opinion that the principles of the Agricultural Produce Grading and Marking Act should also be applied to food products other than agricultural, with the object of improving their quality, and would suggest that early consideration should be given to this recommendation.

## CHAPTER VI

### HEALTH EDUCATION

#### Introduction

1. Closely linked up with the problem of physical education is that of health education. Personal and environmental hygiene constitute two important aspects of the public health problem, and in order to secure a progressive improvement in respect of both, it is essential that the people, children and adults, should be so educated as to adopt and practise the hygienic mode of life and to refrain from doing what may prove harmful to their own health and to the health of others. According to modern conceptions, health education includes "not only instruction in purely health matters, but also those activities which are likely to influence favourably an individual's health knowledge, health attitude and health habits. Health education must promote health and health consciousness, and these are best achieved when health practices become part of an individual's daily life."

#### The Importance attached to Health Education in some progressive countries

2. A great deal of attention is paid to the subject of health education in the West. In England, there is a central Committee for Health Education which works in collaboration with the Ministry of Health. In Australia, there is a regular and carefully drawn up course of instruction in health and hygiene prepared in association with the Health Department for all pupil teachers in the training colleges. In America, there is a new development whereby an attempt is made to train a type of individual called "Health Educator"—a person whose background is that of a teacher and to whom additional training in public health is given. Great importance is attached in Russia to health education and a large amount of money is spent annually on research and on the preparation and execution of schemes calculated to improve and preserve the health of the community.

#### Health Education in India

3. In India too, health education is gradually taking its proper place in the life of the people, but progress in this direction has so far been slow. In reviewing the activities in this field, we may refer separately to the health education programmes for school children and for the general public. The teaching of hygiene is compulsory in all ordinary schools and it is also a subject of study in the curriculum of all normal schools and teachers' training institutions, but the standards of teaching vary from province to province. Speaking generally, the teaching is more theoretical than practical. This is perhaps due to a variety of causes. In many schools, particularly in the rural areas, the buildings and the compounds are kept in a condition which is far from being satisfactory from the hygienic point of view, while the provision of sanitary conveniences and of washing facilities is often of a primitive type or altogether absent. In the circumstances, the pupils are not in a position to practise what they are taught in the class room. Further, the teacher is, in many cases, hardly an example to the students in the matter of



personal hygiene. In the case of children and even of adults, example is much more important than precept in influencing the life and conduct of those who are to be taught. We would not place the blame wholly on the teacher. In many parts of the country the primary school teacher is so inadequately paid that, with his responsibilities for the maintenance of a wife and children, his standard of living necessarily becomes low as well as the level of personal hygiene which he is able to keep up. School children, when trained in such unsatisfactory surroundings and under the influence of teachers, whose example may exert no beneficial influence on them, must naturally fail to profit by the theoretical teaching of hygiene imparted to them. A Joint Committee of the Central Advisory Boards of Health and Education, which investigated the health problems of school children in 1941, made the following remarks regarding health education in schools:—

“While the general situation on paper sounds satisfactory, the low standards of personal and environmental hygiene met with in many schools are such as to forbid an easy acceptance that all is well. These low standards lead to the conclusion that something is wrong with the content of the syllabuses and the methods of teaching hygiene both in training institutions for teachers and in schools for children.” The position thus summed up by the Joint Committee in 1941 has not materially altered in the subsequent years.

4. As regards the general population, health education is mainly carried out by the provincial public health departments. In most provinces a special health propaganda organisation exists in the office of the Director of Public Health. The activities of this organisation include the holding of periodical exhibitions at different places, more particularly at fairs and festivals, and the preparation of leaflets and pamphlets and of suitable material for health talks with magic-lantern demonstrations. In some provinces, motor vans stocked with suitable propaganda material, including facilities for the exhibition of films and of lantern slides, are also maintained and the message of health is carried far into the rural areas.

5. In certain provinces, a good deal of hygiene publicity work is also being done in the rural areas by some other departments of government. For instance, in the Punjab, the Rural Reconstruction Department and the Cooperative Department have been actively co-operating in the health education of the people. The Rural Reconstruction Department maintains cinema lorries which give suitable and specially prepared shows in the villages emphasising the health part of the village uplift programme. Models, made of wood or clay are prepared showing a good village, a bad village, a sanitary and an insanitary home, a sanitary well, various types of latrines, etc. At every fair of note in the province, useful and instructive cinema shows are invariably arranged. Quite a number of uplift songs have been recorded and are distributed free as well as sold at reduced prices. This Department has also devoted its publicity efforts to the popularisation of manure pits in the Punjab villages and attempts have been made everywhere to persuade villagers to have ventilators and chimneys in their houses. Grants are also made for construction of sanitary wells. A special campaign against malaria has been organised and thousands of mosquito-breeding pits and pools

have been filled up or sprayed with oil. Women welfare workers have been appointed, one in each of the 113 tehsils of the province. The Punjab Co-operative Department has ably seconded the efforts of the Rural Reconstruction Department, and quite a number of "Better Living Societies" and "Co-operative Medical Aid and Public Health Societies" have been established. We are aware that health education on somewhat similar lines has been carried out in other parts of the country as well as the organisation of co-operative effort to solve local health problems. For instance, anti-malaria co-operative societies have been in existence in Bengal for many years. We have drawn attention to what has been done in the Punjab only to suggest that similar activities should be developed wherever health education work has not so far received adequate attention from the authorities concerned.

While summing up what has been achieved in this field in the provinces, we must, at the same time, express the view that, possibly, in no province, has health education come up to the standard reached in the more advanced countries.

## OUR RECOMMENDATIONS

### Health Education in Schools

6. We are in general agreement with the recommendation of the special committee of the Central Advisory Boards of Health and Education that the instruction of school children in hygiene should begin at the earliest possible stage and should not be left, as it is at present largely left, to the secondary and high school period. In the early stages, such instruction should be entirely practical and devoted to the formation of health habits and promotion of personal hygiene. In order to emphasise the practical aspect of health education, every effort should be made to improve the existing conditions in regard to the school and hostel buildings, class-rooms, compounds, latrines etc., so that the student may see, in actual operation, the sort of hygienic and sanitary arrangements he is taught and encouraged to demand for himself.

It is particularly important that the primary school teacher should be a practical enthusiast as regards personal and environmental hygiene, for on his teaching and example will largely depend the formation of all those habits and the development of those ideas and aptitudes which are essential for healthful living. We have already indicated that economic reasons may largely be responsible for the present primary school teacher not being able to set an example to his pupils in the matter of personal hygiene. We believe that a marked improvement in the present situation will arise only when a better class of teachers, with a higher standard of training and better emoluments, becomes available as the result of the post-war educational programme.

The active co-operation of school clubs and societies should be helpful in the development of health education. The Boy Scout and Girl Guide movements, the Red Cross and St. John Ambulance Associations are contributing a substantial share to the spread of health knowledge in the wider sense of the term. In addition to the activities carried on by these, we recommend the formation of "Health Clubs" and the celebration of "Health Weeks", "Safety

First Weeks'', and ''Clean-up Weeks'' in order to assist in the development of health consciousness among the school population.

### **Health Education of the general population**

7. While voluntary organisations, such as the Indian Red Cross Society, the British Empire Leprosy Relief Association (Indian Council) and various health associations in different parts of the country, have been participating in the health education of the people, the main responsibility for assisting and guiding such activities should rest, in our opinion, on the health departments of Governments. We, therefore, recommend the establishment of a properly constituted Health Publicity Bureau as part of the Central or Provincial Health Department. While, in the majority of the provinces, such an organisation exists, there is at present no corresponding organisation in the Central Health Department. The establishment of such a bureau at the Centre appears to us to have been long overdue. Its functions should include participation in the active promotion of health education among all sections of the population and the giving of suitable advice and help to Provincial Health Departments in the organisation of health propaganda in their own territories. One important duty of this Bureau should be the publication of an Indian Health Journal. There is a good deal of suitable material and literature, local and foreign, available in the Central Health Department, which in the absence of such a Bureau, cannot be utilised as profitably as it could be.

8. We also desire to see the existing organisations in the provinces strengthened with properly trained staff and equipment for undertaking health education on an extensive scale and for preparing suitable propaganda material. The organisation of health propaganda is a highly specialised task and it should be entrusted to persons capable of producing results. The relatively small achievements so far recorded in this field are probably due to the fact that this important branch of health activity has generally been entrusted, in the past, to people with little or no practical training in the subject.

9. While such intensive efforts will no doubt help, to a large extent, to educate the people in health matters, the part which sound health administration can play in achieving the same purpose should not be forgotten. The doctor, the nurse, the midwife and, in fact, every health worker will, in the faithful discharge of his or her duties, be educating the persons with whom they deal, in regard to the prevention of disease and the promotion of positive health. The instruction so given to individual persons will we have no doubt, prove to be more effective than health talks and cinema or magic lantern demonstrations to large audiences, because the personal relationship which the health worker establishes with such persons will help to make them more responsive to his advice.

10. The methods of propaganda which commercial organisations, such as the Indian Tea Association, have employed with great success should be studied and adopted as far as practicable in the development of the health education campaign.

We also recommend the establishment of permanent Health Museums in the larger towns and cities.

## CHAPTER VII

### PHYSICAL EDUCATION

#### Introduction

1. In this chapter we shall deal with physical education as a means of attaining and preserving health.

Not long ago, physical education used to be synonymous with some sort of old-fashioned, mechanical drill forced on unwilling students by a stern-looking, rough and tyrannical instructor who lavished abuse and made a free use of his fists and cane on his unfortunate victim. A so-called "drill period" was included in the timetable of every school, but no pupil looked forward to it. In addition to drill, there used to be in some schools, parallel and horizontal bars on which boys were forced to perform some gymnastic exercises, irrespective of their state of health or capacity to undergo strenuous exercise. No one looked upon physical education as an integral and important part of general education, and for many years it was almost completely neglected. Even in the United Kingdom, it was not before 1905 that public attention was focussed on the subject as a result of the publication of the report of a Royal Commission on Physical Training in Scotland. The Education Act of 1907, the great work in this field of Sir George Newman, who was then the Chief Medical Officer of the Board of Education and the Education Act of 1921 placed health and physical education and training in the fore-front of educational schemes and programmes. During the last two decades, revolutionary changes and developments have taken place in all the civilised countries of the world, in the concept and content of physical education and training. There has been considerable research, old theories have been exploded and the modern system of physical culture has developed into a science. It is now universally recognised that proper physical education plays a very important part in the intellectual and moral development of a people and that any time, effort and money spent on it are fully justified.

#### Modern trends in Physical Education

2. It will be helpful if a brief description is given here of the modern trends in physical education and training in certain western countries.

*England.*—In the elementary schools in England, there is physical education of a kind, but not necessarily carried out by trained instructors. In the public schools, great stress is laid on games, sports and physical training in general. As every one knows, love of sport in England permeates the country as a whole, nevertheless, it would not be correct to say that a national policy in regard to physical education has been developed there yet. We understand, however, that the Ministry of Education in England is working out a very comprehensive scheme of physical development for all.

*Australia and Canada.*—"The National Fitness Act" was passed in Australia some years ago. Under this Act, a National Fitness Council has been formed. For a population of 7 millions, the Commonwealth Government grants a subsidy of £72,000 per annua. This would, represent, on a population basis, an annual provision of

about Rs. 4 crores in India. We understand that, but for the War, the Australian subsidy would have been much larger.

The trend in Canada is well illustrated by the fact that a number of towns in one province decided that, as a War memorial, they would build up recreation centres instead of raising statues.

*The United States of America.*—There is an increasing tendency in the United States to substitute athletic games for the classic European gymnastics. The physical training syllabuses for children are regarded as an essential part of their general education. Sport has made headway in all classes of the population in the United States. It is intensively organised, especially by the National Recreation Association. In the schools a gymnasium is a standard equipment, although many rural schools have not got it yet. The employment of physical education teachers is quite extensive in the cities, but it is not so common in the rural areas. Parks and playgrounds have been and are being developed in the cities. As in England, the boy Scout and Girl Guide movements are highly developed.

The Bulletin on the Health Organisation (Vol. VI, No. 4, August 1937), League of Nations gives the following information regarding physical education and training in some other countries:—

*Germany.*—Great efforts were made in Germany in the field of physical training since the first world war. The new title of "sport specialists" had been introduced. It could only be claimed after fulfilling various conditions, the taking of a special course in the technique of the physical examination of athletes, participation in various athletic exercises, etc. Field sports became, in fact, a national feature and there were over 3,000 youth hostels in which more than five millions slept and where every kind of facility was made available in the matter of prizes, travel and equipment. Youth was organised on the principle of self-government, that is, management was entrusted to the young people themselves and all the group leaders were drawn from the ranks. The Hitler Youth Organisation included six million boys and girls of various age groups. Beginning in the school, physical education continued in the Labour Service Corps—compulsory for all youths between 18 and 20. Adult physical education was in the hands of the State Association for Physical Exercise. Sports were compulsory in all higher educational establishments.

The Labour Front included over three million members and catered for every type of sport. The training of leaders was very actively pursued and an academy of physical training was set up in Berlin.

*Scandinavia.*—To the Scandinavian countries belongs the honour of originating the so-called Swedish system—a great success in its day which still survives in a modified form. Its founders believed that development of the body was a sufficient goal in itself. This system has been greatly modified since it was first introduced.

*Denmark.*—A fact, which deserves attention, is the extent to which the system of physical education prevalent in Denmark has spread in rural schools where the physical training instructors are peasants who carry out their work without pay, and who are able to improve their own knowledge by means of special training courses lasting four weeks. The marked growth of popular physical culture

in Denmark is due to a careful university training of gymnastic teachers, who are also concerned with the teaching of other subjects and whose training includes a study of theoretical and practical physiology.

*Italy.*—Before the war physical training of young people in Italy reflected the modern tendency to apply methods of physical culture to all individuals, starting from the principle that the best means of raising the physical standards of adults is to improve the physique of the young. The Italian methods of physical training, were based on the official policy of the "nation in arms". This educational movement reacted very favourably on sports organisations, and their number increased considerably. University sports also made considerable headway. Again, sports training was very popular in all industrial circles where the question of workers' spare time was in the forefront.

*Czechoslovakia.*—A national physical training system, which is worth studying, is that of the Sokals in Czechoslovakia based on patriotism. In pre-war Czechoslovakia, the importance of physical training had long been recognised. The educational value of physical culture was emphasised, and its beneficial effect on the personality of the child extolled. A completely modernised system of physical training was available to all classes. In 1934, there were 105 gymnastic and athletic societies with a membership of 2,085,322 (over 15 per cent of the whole population). The Ministry of Public Health and Physical Education played an important part in directing, coordinating and subsidizing these activities. Czechoslovakia had modernised the syllabus for school gymnastic and physical education for girls and boys of all ages. Sport was also held in honour in Czechoslovakia. Tennis was a national game.

*Russia.*—Russia, like the United States, is not bound too rigidly by classic methods. Physical education accounts for a considerable part of the general educational programme. The natural methods of the active school are followed. The pupils are required to display the maximum initiative and activity, as their exercises are not artificial but practical and, therefore, natural. All physical training is under medical supervision. There is an organised programme and there is a large number of schools for training physical-education teachers. The course covers a period of four years and there is a large budget provision for physical culture. A Council of Physical Culture was organised in 1924 and the Chairman has cabinet rank.

### **Physical Education in India**

3. Something has been done in India also to give physical education and training their proper place in the educational structure, but a great deal remains to be accomplished, and it is only fit and proper that the subject should be prominently borne in mind when considering schemes for the amelioration of the physical, social and intellectual condition of the people of the country. Hitherto, the tendency has been to place too great an emphasis on the purely academic side of education. Education, to be complete, must be based on a comprehensive plan which does not ignore or neglect any factor calculated to influence the development of the child.

Given suitable plans and facilities, the success of any scheme of physical education primarily depends on the teacher, and it is regrettable that in India there is a great dearth of suitable teachers.

qualified to impart instruction in this important subject. Children learn more by example than by precept, and the teacher in charge of physical education should, therefore, possess qualities which cannot fail to impress the child with whom he is brought into contact. We consider that, in addition to a knowledge of the principles and practice of physical education, the teacher should possess sound health and good character combined with understanding and sympathy. Where thousands of such teachers are required not even hundreds are available. To produce such teachers in adequate numbers we require several suitably equipped and staffed physical education schools and colleges in the country. We understand that, at present, there are only five physical education colleges in India. These are (i) The Y.M.C.A. College, Madras, (ii) The Training Institute in Kandivali, Bombay, (iii) The Physical Training Centre, Calcutta, (iv) The Physical Education College, Hyderabad (Deccan) and (v) The Lucknow Physical Education College. We were told that there used to be a very good Physical Training Education College at Lahore, but that it has not been functioning during the last three or four years because the premises and grounds were placed at the disposal of the military authorities.

### OUR PROPOSALS

4. Our proposals fall under two heads, namely, those which relate to:

- (1) the training of physical education instructors and
- (2) the organisation of a physical training programme which will include, within its scope, all sections of the community.

#### The Training of Physical Education Instructors

According to a rough estimate, the total number of physical training teachers trained at the institutions referred to above, during the last 20 years, does not exceed 3000. This number is far too small for the needs of the country, and if the proposed post-war schemes of education are to be implemented in every province and Indian State, thousands of qualified physical training teachers will be required. The first step to be taken in this direction is, therefore, the starting of some more physical education colleges, and we recommend that there should be one or two such institutions in each province according to its needs. Each institution should grant a recognised qualification. Apart from the requirements of the secondary schools and colleges, thousands of teachers will be needed for our primary schools, and we suggest that in the normal schools—where vernacular teachers are trained—physical education should be, if it is not already, a compulsory subject. We understand that the post-war scheme of education envisages the starting of a large number of such normal schools in every province. Further, in every training college for teachers of secondary schools—and their number is also bound to be increased in the near future—adequate emphasis should be placed on physical education. Thus a regular stream of teachers qualified to participate in the physical education programme, will, during the next two or three decades, continue to flow from these training institutions, and we believe that they will all be needed to promote an intensive scheme of physical education in the growing numbers of schools and colleges, which the post-war education scheme will bring into being.

While, under the above proposals, all teachers in primary and secondary schools will be equipped to participate in the programme of physical education, the leaders in this field will obviously be those who undergo the full and intensive course of training provided in the physical education colleges. It is desirable that at least all the secondary schools and colleges should have, in due course, one or two such physical educationists on their staff, while all the administrative posts in the provincial organisation, we are suggesting below, will also be filled by such persons. Our suggestion that all teachers of primary and secondary schools should be trained to take part in the development of the physical training scheme has been actuated mainly by two reasons. One is that the nation-wide programme of physical culture, which we are advocating, cannot be undertaken without an army of instructors and, as will be shown later, teachers are, in our view, well-fitted to fill this role. The other is that the usefulness of physical instructors will be on the wane after a certain age and, therefore, it seems to us an advantage if such men also possess the additional qualifications of an ordinary teacher on the academic side, so that they can, during the last 10 or 15 years of their service, be diverted to the purely teaching line.

In addition to the development of such training facilities in India, we suggest that a certain number of highly qualified physical training instructors should be selected and sent abroad at State expense for higher training on the most up-to-date lines. On their return to India, they should be employed in responsible administrative and teaching posts where their special training will be of value.

### **A Physical Training Programme for the Community**

The programme should make provision (1) for the students of schools and colleges and (2) for the general public. It seems to us that, at least in the beginning, it may be advantageous to develop a single organisation to serve the needs of both these sections of the population. The anticipated expansion of post-war educational activity will probably bring schools to almost every village or group of small villages in the country and, if our suggestion for the training of all teachers as exponents of physical culture is adopted, it should be possible to provide a sufficient number of trained workers, even in the rural areas, to develop physical culture activities not only in schools but also outside them for the benefit of the general community. The campaign for improved community health through physical culture will require enthusiastic workers, who through their own zeal can help to rouse a similar response from the people. In our view the schoolmaster, because of his general education and of the influence he is able to exert on successive groups of pupils with whom he comes in contact and on their parents, is favourably placed for stimulating such response from the public.

### **Provincial Organisation**

5. For promoting the development of a physical training programme on a broad basis, it will be necessary to establish a suitable organisation in each province and, for the reasons already suggested, this organisation may, with advantage, be made part of the provincial Education Department. In this connection, it may be mentioned that, in the Punjab, there are suitably qualified officers



designated as "Assistant District Inspectors for Physical Training who are attached to the district inspecting staff of the Education Department. It is a part of their duty to encourage the establishment and maintenance of village games and sports clubs for adults, and we gather that much useful work has been done in this direction by these men. In our opinion, not only should there be one such officer for each district, but one for each Tehsil. At the provincial headquarters, there should be a highly qualified physical educationist with the rank of an Assistant Director of Public Instruction, who should act as the adviser to the Director of Public Instruction. In the larger provinces, a suitable number of regional officers for groups of four or five districts may also be found necessary.

### **Emphasis on National Games and Exercises**

6. Another matter we desire to emphasise in connection with the national physical education programme is the need for incorporating in it, as far as possible, various forms of physical training, games, sports and folk dances which are prevalent locally in different parts of the country. These embody in themselves the genius innate in the people for organised recreational activity, and it is in the national interest that such of them as possess real cultural value should be preserved and not permitted to die out. Apart from this, these activities are generally less costly, from the point of view of development and maintenance, than games such as cricket, hockey and tennis and, in the large scale scheme of physical training we are advocating, the question of cost cannot be ignored. We do not suggest that the newer forms of recreational activity that western education has brought into the country should be brushed aside. What we desire to see is a blending of the old and the new in an attempt to evolve a sound scheme of physical culture, which provides for the training of the physique through gymnastic and other exercises as well as for the development of that alertness of body and mind, of discipline and of team spirit, which results from corporate recreational activities conceived on as wide a basis as possible. It is such a system of physical culture which we desire to see developed for the student population and for the general public. This will be possible only if the programme of training in physical education for teachers in training schools and colleges is drawn up in accordance with the suggestions put forward here.

### **Physical Education Programme for the Student Population**

7. In addition to the different forms of physical exercise and recreational activity, which will be developed in the schools and colleges, we desire to see as wide an expansion as possible of the Boy Scout, Girl Guide, the Junior Red Cross, the Hindustan Scout, the Bengal Bratachari and similar movements, which can make valuable contributions to the well-being and disciplined training of the youth of the country. It is desirable that, when fully trained physical educationists become available in sufficient numbers, the programme in each school and college should be developed under an instructor with such training.

Certain persons are not able to stand physical strain to the same extent as others and it is, therefore, necessary that, in schools and colleges, physical instructors and school medical officers should co-operate in order to ensure that, in individual cases, the physical training given is regulated in accordance with the medical advice of

the doctor. We shall deal with this subject in the chapter containing our recommendations for health services for the school-going population.

### **Physical Education of the Adult Population**

8. We recommend that, in cities and important towns, local authorities should direct more attention than has so far been given to the organisation of suitable forms of recreation for the non-student population. Playgrounds, parks, wrestling arenas and swimming pools should be provided, and the need for including such requirements should be kept prominently in view in any schemes of town planning that may be undertaken. All existing voluntary organisations promoting amateur sports should be encouraged and, wherever possible, given grants-in-aid. While local authorities should be made the instruments for carrying out this scheme of physical education for the general community, the Governments should help them financially and with technical advice. The provincial organisation, which we have recommended, will be responsible for giving such advice and for recommending the distribution of grants-in-aid for the development of physical education schemes.

### **Physical Education for Women**

9. Any scheme of physical education will not be complete unless suitable provision is made in it for girls and women and we attach the greatest importance to a proper system of physical training being evolved for them. In training a boy you train an individual, in training a girl you train a family. Girls would, of course, need a somewhat different type of physical education to that designed for boys. This aspect of the question, as also the very difficult problem of financing and training an adequate number of women teachers, will, we earnestly hope, receive the careful and sympathetic consideration of the authorities concerned.

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## CHAPTER VIII

### HEALTH SERVICES FOR MOTHERS AND CHILDREN

1. We consider in this chapter and in the succeeding two chapters special services for three separate groups of the community, (1) mothers and children, (2) school children and (3) industrial workers. The reasons for developing such special services will be set forth in detail in the appropriate places. We must emphasise, in our view, that such services should not be considered as functioning independently of the general health organisation for the community. The ultimate aim of a national health service is to ensure continuity of health protection to every individual from the prenatal stage, through childbirth and the subsequent years of life right up to death. The special services mentioned above are intended, through certain specific duties which they perform in respect of particular sections of the community, to supplement the provision for health protection which the general health organisation makes available to all. It is essential, however, to recognise the organic unity of such special services and of the general health organisation. We have kept this in view in formulating our proposals for the development of personal services for each of these three groups of population.

### MOTHERS AND CHILDREN

#### Introduction

2. Our review of the existing health conditions in respect of these sections of the population contains abundant evidence to show the importance and urgency of providing adequate measures for the protection of their health. It was pointed out that, on a conservative estimate, about 200,000 women died annually from causes arising out of childbirth in a year in British India, and that the number of those who suffered from varying degrees of disability resulting from the same causes must be many times that figure. No estimate of the extent of maternal morbidity in India can be made except, perhaps, in an imperfect way by basing our calculation on the experience of some other country. In a recent Report on National Maternity Service (May 1944) issued by a Committee appointed by the Royal College of Obstetricians and Gynaecologists in England, it is stated that "Blair-Bell estimated that for every woman who dies as a result of pregnancy or childbirth, 20 suffer from impaired health and lowered efficiency." If this proportion can be applied to India, the number of women, who are made to suffer ill-health as the result of pregnancy and childbearing will each year be about four millions. Apart from the suffering and loss that these figures for maternal morbidity and mortality reveal, the adverse effect produced on home life by the continued illness of the mother or by her death at a comparatively early age can hardly be estimated, particularly from the point of view of the health and well being of the surviving children.

3. As regards child mortality, it has been shown in our survey that nearly half the total annual deaths at all ages in British India take place among children under ten years and that, of these, about half the number is among those under one year of age. It is, therefore, clear that measures directed towards reducing sickness and mortality among mothers and children must have the highest priority in any programme of health development in this country.

4. Before making detailed proposals for providing health protection to mothers and children, we may enunciate certain general principles which should govern the development of the requisite services.

Childbearing should normally be a physiological function for the woman and, although certain demands would be made on her for meeting the prenatal needs of the child, she should, under reasonable conditions of life, be able to adjust herself easily to these requirements. On the other hand, when she is sick or in a subnormal state of health, which may often be associated with socio-economic causes promoting adverse conditions of life such as malnutrition and/or undernutrition, overcrowding and undue physical strain through overwork, childbearing becomes invested with a measure of risk much greater than that which a healthier person placed under more favourable conditions has to face.

5. It follows, therefore, that the special steps taken to promote healthy motherhood must include not only medical measures but also certain ancillary services designed to mitigate or remove the socio-economic factors mentioned above. It also follows that our ultimate aim should be not merely to safeguard maternity but also to provide adequate health protection to all women, in order to ensure that the function of motherhood is undertaken under optimum conditions of health. Special services for the protection of maternity will no doubt be required, but these services should be developed as parts of the wider organisation for providing adequate health protection to all women.

The health of the mother and the health of the child, particularly at the younger ages, are so closely related as to be almost inseparable. At the prenatal stage and during confinement the health of the child and even its existence are largely influenced by the health of the mother. During the first few weeks and months following childbirth, the infant is generally in such close association with her and so dependent on her for sustenance that any illhealth affecting the latter has its natural repercussion on the child. Later too, it is the mother's watchful care that wards off the adverse effects of an alien environment to which the growing child has to adjust itself and, if sickness or ignorance of mothercraft prevents her from exercising the requisite care over her baby, the latter must, in the majority of cases, suffer the consequence of such neglect.

In these circumstances, it seems essential that the proposed health organisation should deal with mothers and children together.

6. For the sake of continuity of service it is desirable that, as far as possible, the same doctor, midwife and public health nurse should be responsible for the care of the mother and child. Thus the supervision exercised over the mother during the antenatal period, during confinement and in the postnatal period will be uniform. From the point of view of the infant, it is of advantage if such continuity of service can be maintained during infancy and the subsequent years of childhood.

## OUR RECOMMENDATIONS

### Certain Preliminary Considerations

7. The proposals that are embodied in the short and long-term programmes of health development, that we have recommended in an

earlier part of this report, incorporate the principles indicated above. The maternity and childwelfare organisation will be an integral part of the general health service and is intended to provide domiciliary and institutional health protection for expectant and nursing mothers as well as for infants and children. In each local area the same medical officer, public health nurse and midwife will deal with women during the antenatal stage, confinement and the postnatal period. Similarly, the same staff will ensure continuity of service to the growing infant throughout the period of childhood. While the pattern of the health service for mothers and children will be same in both the short and long term programmes, inadequacy of trained staff and of funds will, during the short term, limit the range and quality of the service that can be made available.

### Short-Term Programme

#### Primary Unit

8. The staff available for this branch of health activity in a primary unit will consist of a woman doctor, four public health nurses, four midwives and four trained *dais*. The institutional service will consist of a dispensary at the headquarters of the unit and a hospital of 30 beds serving four such units together. At the dispensary there will be provision for four beds, of which two will be for maternity cases. In the 30-bed hospital six will be set apart for maternity and gynaecological cases and there will be 4 cots for children. It is understood that certain Provincial Governments are proposing the establishment of maternity homes. Any provision in these homes above the minimum we have recommended will be welcome.

9. The population of a primary unit will be approximately 40,000. The average area covered by it will vary considerably, from about 51 square miles in Bengal to 425 in Sind. Only in four provinces, however, will it exceed 200 square miles. If the last figure is, therefore, taken as the average area of a primary unit in British India, as a whole, we shall be making a reasonably correct estimate. It will be recalled that, in our short term scheme, we have suggested that each primary unit should be divided into four circles, of which one would be associated with the headquarters of the unit, and that in each of these four circles, there should be stationed a public health nurse, a midwife and a trained *dai*. The radius, within which each of them will then have to operate, will be about 4 to 5 miles.

10. On the assumption that the birth rate is about 40 per mile each circle with its population of 10,000 may be expected to have 400 births per year. Each midwife and the *dai* will, therefore, have to deal with 200 births in a year, which is twice as much as can be effectively dealt with under normal conditions. Until the service becomes sufficiently popular, it is unlikely that all the expectant mothers in the area will avail themselves of the facilities that are offered. We may, therefore, expect that, in the early stages, our service will be availed of by only a proportion of the number of pregnant women in the area, so that the demands on each midwife and *dai* are not likely to prove excessive.

11. At the headquarters of each primary unit and in the places in which 30-bed hospitals are located, the services of a medical officer will be available and there will also be provision for a small number

of maternity beds. With such facilities, and with the aid of the public health nurse, midwife and trained *dai* stationed at these places, it should be possible to organise a maternity and child welfare centre, the range of activity of which can be expanded as and when more trained personnel and funds become available and communications improve. A weekly clinic should be held by the doctor at this centre. The functions of such a centre should include the following:—

(1) To get in touch with as many pregnant women in the area as possible and to persuade them to visit the clinic regularly. On the first visit, a detailed examination of the expectant mother, general and obstetric, should be made and a record of her medical history kept. At subsequent visits advice in respect of the hygiene of pregnancy and instruction regarding diet will be given. Further, it should be possible to make an early diagnosis of any deviation from normal health, to give appropriate advice and timely treatment for such diseases as tuberculosis, syphilis, anaemia and toxæmias of pregnancy or to refer the patient to institutions or specialists for medical attention.

(2) To provide for the skilled assistance of a midwife or trained *dai* at the time of delivery and for domiciliary visits by a public health nurse for two weeks thereafter. A record of the confinement and of the immediate postnatal history should be added to the card of the mother and a new one opened for the infant.

(3) To keep the mother and child under observation, if possible, for a year. It is desirable to keep a weekly weight record of the infant. Advice to the mother should be given in respect of lactation, diet and exercise and, at a later stage, in respect of weaning. Treatment, where necessary, should be given and extra nourishment to mother and child should be made available, if required.

(4) To teach mothercraft in all its branches with practical demonstrations, special emphasis being laid on the inculcation of sound hygienic habits in the mother and child.

(5) To keep children under observation, if possible, up to five years. Weight and progress records should be kept. From the second year onwards monthly visits would suffice, but mothers should be instructed to report any illness arising between visits to the clinic and a domiciliary visit by a doctor should, in such cases, be arranged.

(6) To organise occasional talks, by suitable persons, for husbands and fathers in order to secure their co-operation,

(a) in the care of their women especially during pregnancy,

(b) in the advisability of spacing the births of their children,

(c) in child-psychology,

(d) in aiding their wives in the maintenance of hygienic surroundings and in providing a well-balanced diet for the family and

(e) in the development of the faculties of children by means of manual occupations, special toys, games, etc.

(7) To give instruction on birth control. We have discussed this subject elsewhere in this report, and have expressed the view that, where considerations of maternal health so require, it is definitely the duty of the State to provide facilities for imparting such knowledge. We have further expressed the view that the imparting

of information regarding birth control by Government agencies should be limited to institutions such as maternity and child welfare centres and hospitals and dispensaries which render medical aid to women.

12. The centre should be provided with a weighing machine, a pelvimeter, an examination table and equipment for testing urine, taking the blood pressure, estimating haemoglobin, taking blood for laboratory examinations, etc.

13. Whenever practicable, a playground for children of two to five years of age should be provided as close to the centre as possible with toilet accommodation for mothers and children, quite apart from the bathrooms where the bathing of infants and children is carried out.

14. The centre should aim at becoming the focus of social activity in the area as far as mothers and children are concerned. The mornings should be devoted purely to health measures while certain afternoons during the week should be set apart for such things as needle work and knitting, invalid cookery, the management of children, home nursing, etc. An enthusiastic social worker should be selected for promoting such activities. Whenever favourable opportunities arise, talks should be given on health, on gardening with special reference to the raising of vegetables, and on current topics of general interest.

15. Although we realise that the activities outlined above may not be possible of development so as to cater to the needs of the whole population of each primary unit during the early stages of the programme, we have described at some length the scope and nature of the work that the maternity and child welfare centre should perform because we feel that this institution, with its combined attack on the health and social problems of the Indian home, is bound to play a vital part in the programme of national reconstruction. If the principles of hygienic living can be inculcated in the women and children of the country, no better foundation can be laid for building up the public health. Further, the wider outlook, which the social activities suggested by us at the centre are calculated to promote will, we have no doubt, help to raise the general level of welfare in the community.

16. Here is a field in which the active co-operation of the officers of all departments of Government concerned with the promotion of social welfare will be of great value in advancing the work of the centre on sound lines. The maternity and child-welfare centre will form the focus from which the health care of mothers and children will radiate into the homes of the people. The woman doctor, the nurse and the midwife should supplement the medical attention provided at the centre by such advice and treatment as may be possible for them to give during their domiciliary visits. The vast majority of the confinements will, during this period, have to be conducted in the homes of the people. The two maternity beds, attached to the dispensary at the headquarter of each primary unit, and the six beds for the same purpose at the 30-bed hospital, can provide accommodation only for the most urgent cases. The conditions prevailing in many homes are likely to be far from being satisfactory for the conduct of delivery and, until the general housing and economic position improves considerably, these conditions may not show any material change. Some improvement will, no doubt, be

possible in all except perhaps the homes of the poorest people if the housewife can be given proper instruction to prepare her home for the advent of the new baby through such changes as she can probably effect within the limits of the family income. The extent to which the nurse and the midwife have won the confidence of the housewife will determine largely the degree of success which their efforts in this direction will attain. We recommend that standard sanitary outfit should be made available in all necessitous cases.

17. In the three peripheral circles of each primary unit, the resident staff will be only a public health nurse, a midwife and a trained *dai*. It is anticipated that the woman medical officer will be able to visit the headquarters of each of the three circles (the fourth being the headquarters of the primary unit) once a fortnight. The public health nurse should hold a weekly clinic, while the medical officer will attend every alternate clinic. The same lines of activity should, as far as may be practicable, be followed in the peripheral circles as those described for the maternity and child-welfare centre at the headquarters of the primary unit. The nurse will normally carry out such routine treatment as will be prescribed by the doctor during her visits, while the latter will undertake all higher types of work required in respect of the women and children attending the clinics.

18. We have already referred to the importance of improving the nutrition of these women and children as an essential step towards the promotion of their health. Necessary provision has been suggested in the budget for each primary unit and the matter will be referred to in greater detail later in this chapter.

#### **Headquarters of the Secondary Unit**

19. At the headquarters of the secondary unit the 200-bed hospital should have, it is suggested, about 50 beds for maternity and gynaecological cases. In the second five-year period of our short-term programme the 200-bed hospitals constructed during the first five years will, we hope, be enlarged so as to provide 500 beds. In this case the provision for maternity and gynaecological cases may be raised to about 125 beds. The better facilities expected to be available in these institutions will make a higher type of service possible, while the telephone and ambulance organisation, we have recommended, will help to extend these facilities to the more serious cases occurring in the primary units.

20. For the supervision of the maternity and child-welfare organisation in the area under our scheme, we have provided, at the headquarters of each secondary unit, an Assistant Administrative Medical Officer and a Senior Public Health Nurse.

21. At the headquarters of each province, there should be, on the establishment of the Director of Health Services, a competent woman doctor with wide experience in the organisation of health services for women and children. It will be the function of this officer to promote the development of these services in the districts, co-ordinate their activities and, by constant supervision, ensure a high level of efficiency.

#### **Utilisation of the Services of Less Qualified Types of Personnel**

22. We recognise that, in the early stages, the staff employed in individual primary units may not reach the standard recommended by us either in respect of numbers or of quality. It will not



be possible with the relatively small number of women doctors, who are available for service at present, to station a woman doctor in each primary unit during the greater part of the short-term programme. Similarly, health visitors, who possess only a lower type of qualification than public health nurses, will have to be employed for some years in place of the latter. Inadequacy of trained midwives will necessitate, for many years to come, the employment of the indigenous *dai* with such training as may be given to her to render her conduct of normal delivery reasonably safe. While recognising the inevitability of such deficiencies in the early stages of our programme, we feel that the proposed organisation is on sound lines and that, when adequate expansion takes place, it may be expected to provide an integrated curative and preventive health service for mothers and children.

### **The Long-Term Programme**

23. By the time the long-term programme is completed, the health organisation will have developed sufficiently to provide a reasonably adequate service. The population to be served in each primary unit will be relatively small, namely, about ten to twenty thousand. Of the three women doctors who will be available, one will be in charge of the maternity and gynaecological ward in the hospital in addition to any other duties that may be assigned to her, while the other two will be engaged on domiciliary service, which will include, within its scope, not only the care of maternity but also the treatment of all forms of sickness among women and children. Four public health nurses will assist these women doctors in the provision of adequate medical care to the people in their homes. Each of these will be a type of nurse who can deal not only with maternity and child welfare work but also with school health, tuberculosis and other forms of preventive health activities. The provision of six midwives, four public health nurses and two women doctors for domiciliary service in a population of about 10,000 to 20,000 should help to ensure a reasonable measure of health protection. The ten maternity and gynaecological beds, to be provided in each primary unit hospital, are intended for the hospitalisation of cases requiring greater care and attention than can be given in domiciliary service.

24. These provisions for each primary unit will be supplemented by the higher type of service which will be available at the headquarters of the secondary unit and of the district. The administrative staff, in charge of the maternity and child-welfare organisation in each district, will also have increased by the time the long-term programme is completed. There will be a Deputy to the Officer-in-charge of the District Health Services, who will be responsible for this branch of health administration, while she will have her counterpart at the headquarters of the secondary unit. At these two places, there will also be corresponding officers for the supervision of the public health nurses. It should, therefore, be possible to ensure that the service for the health protection of mothers and children is maintained at a high level of performance throughout the district.

### **The Training of the Required Health Personnel**

25. The most urgent need in connection with the development of maternity and child-welfare services is, as in the case of the other health services, the production in adequate numbers of the different types of workers. The proposals we have made, in the chapter on

professional education for the training of health personnel, will, if implemented, provide types of workers of all categories who should prove more satisfactory than those who are available at present. Whether it be the doctor, public health nurse or midwife, a deficiency of major importance in the training now given is the absence of facilities for acquiring actual experience of health administration, including domiciliary service. Our recommendations include the requirement that all health workers should have certain specified periods of field training before they become qualified for their respective professions, and this deficiency will, therefore, be met when the new types of doctors and other health personnel become available in sufficient numbers.

26. Another obstacle to a rapid expansion of the maternity and child-welfare organisation is that the existing number of women doctors with the requisite special training and experience is extremely small. In the section dealing with professional education, we have emphasised the importance of providing facilities for specialisation in the different branches of medicine, including maternity and child-welfare, in the programme of postgraduate education. Such specialisation will include obstetrics, gynaecology and pediatrics in order to provide the specialists whose services are essential for the development of an efficient health organisation for mothers and children. Side by side with this, the creation of an increasing number of qualified workers in the lower branches of the maternity and child-welfare organisation will also form an important part of the professional education programme under our scheme.

### **Social and Economic Factors**

27. We have already drawn attention to the importance of the social and economic factors in planning a campaign for the improvement of the health of mothers and children. In our view, the two most important among these factors are inadequate nutrition, which includes malnutrition and under-nutrition, and the strain resulting from overwork either in the home or outside.

### **Nutrition**

28. The pregnant woman, the nursing mother and the growing child require a more generous and nourishing diet than the general population, and they are, therefore, easily affected by reductions in the quality and quantity of the food they eat. The health services for these two sections of the population, howsoever elaborate and efficient, will fail to produce satisfactory results unless simultaneous measures are undertaken to improve their nutrition.

29. We have discussed, in the chapter dealing with nutrition, the problems associated with the task of raising the general level of nutrition in the country. The action required to be taken will cover a wide field and will include such measures as the augmentation, on a large scale, of the production of practically all articles of diet, their storage, transport and distribution, special steps for ensuring that the prices of essential articles of food are brought down to such a level as will place them within the reach of the poorer sections of the community as well as social and economic changes directed towards raising the income of the vast majority of the population. This wide range of administrative measures, which constitute some of the essential steps necessary for raising the general standard of nutrition, forms no doubt an important part of the objectives that

the national post-war reconstruction programme has in view. While the implementation of this programme can alone promote the attainment and maintenance of a reasonable standard of nutrition in the country, immediate steps are necessary to ensure that, among the poorer sections of the community expectant and nursing mothers and children get such supplements to their diet as will help to provide the nutrition required. In our budget for each primary unit, we have suggested the provision of an annual sum of Rs. 3,000 in order to enable the Woman Medical Officer to make suitable additions to the diet of such mothers and children.

### **The Strain Resulting from Overwork**

30. The strain, resulting from overwork, will affect a woman's health both during pregnancy and in the postnatal period. In the section relating to industrial health we have recommended the grant of maternity benefit to, and compulsory abstention from work for a period of six weeks before and six weeks after confinement by, all women employed in industry. We have also recommended that these concessions should, in due course, extend to all women gainfully employed outside their homes. We, therefore, look forward to the extension of maternity benefit to all classes of women workers except those who are subject to undue physical strain in the discharge of their household duties. It is true that in many cases, especially under the joint family system, the expectant mother gets relief from domestic work from her women relatives. But cases are not infrequent where the lone woman has to battle with a whole host of household duties, including the rearing of a number of small children. In such circumstances, adequate rest either before or after confinement becomes impossible. The supply of 'home-help' by the public authority has become a recognised practice in England and other progressive countries, particularly during the lying-in period. The home-help is a woman who keeps the home for the mother while the latter is lying-in at home or in hospital. In Holland, such persons are required to have special qualifications in elementary nursing and in the management and feeding of infants. While, under present conditions, our primary concern should naturally be that of promoting the rapid development of the essential health services, we have no doubt that, in due course, the question of supplying trained assistance to expectant and nursing mothers will have to be considered in this country also, if the harmful effects of undue physical strain on such women are to be avoided.

## **CERTAIN OTHER MATTERS**

### **(a) Nurseries for children**

31. The provision of nurseries or creches to relieve the mother, especially the working woman, from her responsibility for the care of the child during her hours of work, has been a noticeable development in all highly industrialised countries. But the nursery can also be made to play an important part in the education of the mother and the education and proper development, physical and mental, of the child. In this connection, we wish to draw attention particularly to what has been accomplished in the Soviet Union for the development of nurseries as an integral part of the child-welfare organisation. We give as appendix 13 the relevant extract from Professor Sigerist's book, "Socialised Medicine in the Soviet Union"

He points out that, in that country, the nursery has become so standardised that similar institutions are found in Moscow, in the Caucasus, in Central Asia and in Siberia. The institution serves a threefold purpose, namely, that of relieving the mother, of caring for the child and of educating the mother and child. Most nurseries take in about 50 to 125 children. Each institution is, generally, in charge of a woman doctor and she is assisted by a staff consisting of doctors, psychologists and nurses. Besides taking care of the child, from the point of view of health and physical comfort, the programme of the institution is so devised as to develop his social instincts as well as mental faculties and to promote the growth of healthy habits. Separate provision exists for children at the successive ages of 0-1, 1-2 and 2-3 years. The aim is to make them healthy in body and mind, to draw out their innate faculties and to make them self-reliant.

32. The mother visits the nursery to feed her baby and receives her lunch there free of charge. She learns how to feed, dress and take care of her child properly. Such instruction in mothercraft also helps her to take proper care of her later children. The influence that the nursery exerts on the home of the child is also important. Nurses sent out from the institution "inspect the living places regularly in order to find out under what conditions the children live." A more detailed description will be found in the appendix.

33. In Russia, the nursery has been organised mainly for women employed in industry. Sigerist has pointed out that, of the total number of industrial workers, about 89 per cent. were women. Since 1937, when the book was published it is almost certain that this percentage must have risen. At first, the development of these institutions was mainly in urban areas, but with the growth of collective farms and State farms, nurseries spread to the countryside. It seems to us, however, that the establishment of such institutions can help to improve the health and welfare of mothers and children in the general community also. Apart from the medical benefits and physical comforts they provide, these institutions should promote the growth of community life on sound lines through the development of the social instinct in the mother and, to an even greater extent, in the child. There are other advantages also. The opportunities these institutions offer for the health education of mother and child are unique. Equally unique are the opportunities they present to the health workers, and particularly the pediatrician, to study child life in health and disease as well as on the borderland.

34. Can the establishment of the nursery as a part of the maternity and child-welfare organisation be considered as a practicable measure in India? If it is to play its part in the development of child life on proper lines, the nursery service should not be confined to the children of the industrial portion of the community but should include, as far as possible, those belonging to all sections of the population. If nurseries, on the lines indicated above, are established in some of the larger cities of India, they will serve equally the needs of the industrial and non-industrial sections of the population of the areas in which they are located. We recommend that the establishment of such nurseries should be attempted, in the first instance, in provincial capitals. In the beginning, women workers in industry will probably take most advantage of the facilities that are offered. But such facilities should continue to be available to all sections of the community and we have little doubt that.

in due course, these institutions will extend their beneficent influence over the non-industrial section of the population also.

35. In making this recommendation, we are not oblivious of the many difficulties that exist. Even in the larger provincial capitals caste and religious differences, with their restrictions relating to diet and certain other aspects of the life of the people, will probably render it difficult to maintain these nurseries on common lines for all children. On the other hand, a large part of the educative value of these institutions, will be lost if they are developed on sectarian lines. We believe, however, that we are right in assuming that the increased opportunities for the commingling of communities, which the post-war educational programme and developments in other fields of social reconstruction must create, will cause these differences among the various sections of the population to disappear gradually. We also believe that the health services we have recommended will contribute their share to this end, partly through the education that results from the contacts our workers will establish with the people in their homes, and partly through the opportunities that the facilities offered by the health services will create for the people to come together. We, therefore, recommend that those nurseries should not be developed on sectarian lines. The provision made for food, recreation and other activities should be on a common basis for all mothers and children.

#### **(b) Health Education**

36. We consider health education as one of the most important functions of the maternity and child-welfare organisation. The home visits paid by the doctor, nurse and midwife, the consultations with mothers at the antenatal, postnatal and infant-welfare clinics, all afford opportunities for instructing them in the maintenance of their own health and of that of their children. The nurseries, which we have described in the preceding paragraphs, will, when established, provide even greater opportunities for such education.

37. The health education of mothers and children must naturally form part of the wider scheme for similar instruction to the community, as a whole. The measures to be adopted in respect of the latter have been considered in a special chapter. There we have suggested the organisation of the necessary measures on a broad basis so as to include the numerous recognised methods of imparting information, such as the radio, printed literature, personal talks, health dramas, exhibitions and songs, as well as every other channel for placing before the people the importance of health and the method of securing and maintaining it. All this educational work will no doubt, benefit the mother and child, but the most lasting results are likely to be those derived from the sympathetic advice and guidance that individual members of the maternity and child welfare organisation can make available to mothers and children in the course of their daily duties.

#### **(c) Maternity Homes**

38. The establishment of private maternity homes, in response to the growing demand of the public for institutional facilities for confinement, is a noticeable feature in some of the larger urban centres. We wish to emphasise the importance of local health authorities exercising the strictest possible control over the establishment and maintenance of such institutions. The existing homes

should all be registered, inspected and brought up to desirable standards in respect of buildings, staff, equipment and maintenance. The establishment of new institutions should receive the prior sanction of the health authority in order to ensure that due regard will be paid to these requirements. It is desirable that the Provincial Ministry of Health should prescribe suitable standards in respect of these and make it incumbent on local authorities to enforce them.

**(d) Voluntary Effort in the Field of Maternity and Child-welfare**

39. In this, as in other fields of health endeavour, voluntary organisations have played an important role in the past. Enthusiastic voluntary workers were responsible for starting the training of indigenous *dais*, of midwives and of health visitors, all of whom are essential personnel for the maternity and child-welfare organisation. Voluntary societies have also been responsible for the establishment and maintenance of a large number of maternity and child-welfare centres.

40. In 1930 voluntary work in this field was centralised by the establishment of the Maternity and Child Welfare Bureau under the Indian Red Cross Society and the appointment of a Director of that Bureau who could, through the various provincial and local branches of the Red Cross Society, promote the development of this branch of health activity in different parts of the country. Indeed, in certain provinces (*e.g.*, the United Provinces and the Central Provinces) the Provincial Governments concerned have transferred their responsibility in respect of maternity and child-welfare work to the respective provincial branches of the Indian Red Cross Society by giving them large grants and permitting them to develop and maintain the organisation as part of the activities of the Society. The only control that the provincial health authorities have over the organisation seems to be through the representation of health officials, such as the Director of Public Health, on the executive committees of the provincial branches of the Society.

41. While fully recognising the need for and appreciating the value of voluntary organisations in the field of health, we hold the view that their activities should supplement rather than supplant the legitimate functions of Government in this sphere. The implementation of our proposals for health development in the provinces will, no doubt, bring this branch of health administration within the purview of the Provincial Health Department, but the expansion of our scheme over the whole province will take time and, in the areas outside the scheme, the present state of affairs will no doubt continue. We have recommended that the Officer-in-charge of the District Health Services should supervise the development of our scheme as well as control the health administration of the area unaffected by it. In the latter, he may find that he has no authority to enable him to regulate the functioning of the existing maternity and child-welfare organisation. This is far from satisfactory.

42. We are therefore of the opinion that provincial governments should exercise closer supervision and control over the maternity and child-welfare activities of the Red Cross Society and, indeed, of all similar organisations. There is abundant scope for voluntary effort to supplement what governments can do in practically all branches of health service, and every available agency should be utilised in the endeavour to bring effective health services within the

reach of all. But the responsibility for providing such services rests upon the governments, and they cannot relieve themselves of any part of that responsibility by making grants to voluntary organisations over whose activities they have very little control. While voluntary effort should be welcomed and encouraged, it should be so supervised and controlled as to ensure that its health service conforms to the standards prescribed by the public health authorities. This is not ensured by the presence of a representative of the health department on the Committee of the organisation concerned. There must be regular inspection and the governments should have power to take whatever steps may be necessary to ensure that the health activities of voluntary organisations are maintained at a satisfactory level.

### **A Health Card for Every Individual**

43. The ultimate aim of the health organisation is to ensure continuity of effective health protection to every one from the prenatal stage, through childbirth and the subsequent years of life to death. An accompaniment of such care should be the provision of a continuous record of the individual's health. We suggest that every baby should be given a health card as soon as it is born. It should be in duplicate so that one can be kept at the headquarters of the primary unit concerned, and the other given to the parent. On this card should be given information regarding the health of the mother in the prenatal period as well as any details of value in respect of childbirth from the point of view of the child's health. When our health organisation becomes fully developed and covers, within its scope the vast majority of the population, most of the infants that are born will start their life with this health card. It should not be difficult, under the conditions that would then prevail, to enter on the health card of each child, from time to time, such details of sickness and of health as will constitute a running commentary on his physical and mental condition. Up to the end of the school going age, the majority of the children are likely to remain in the place where they are born, so that the entries concerned will be made locally. Up to that stage, it should be relatively easy to keep the individual's card and the one kept at the headquarters of the primary unit filled in properly. In later years when he leaves his place of birth, he could carry his card with him and it would provide an invaluable previous medical history as an aid to diagnosis and treatment.

44. We are not putting forward this idea of a health card for every individual as an objective to be realised in the immediate future. We understand that, even in the Defence Services, with all the advantages of having to deal with a disciplined group of people, the working of the health card system has not been entirely satisfactory. We also realise the far greater difficulties that will arise when dealing with the civil population. In the first place, the citizen must become suitably educated before his or her active co-operation will become available for the successful working of this health card scheme. Secondly, the health services provided for the people must be sufficiently developed in order to enable the individual to secure that continuous medical attention, curative and preventive, which the system requires. While recognising all this, we still venture to put forward this system as an objective for the future to be kept in view by health administrators and the public alike.

## CHAPTER IX

### HEALTH SERVICES FOR SCHOOL CHILDREN

#### Introduction

1. We have already expressed the view that the special services, which are established for certain sections of the population, should not function independently of the general health organisation for the community. In the past, the tendency for such special services to grow up as separate entities has been a noticeable feature in all countries. The reason for this is not far to seek. In our review of modern trends in the organisation of national health services we pointed out that, in no country, except Soviet Russia, has there been developed, as yet, a health service which offers protection, curative and preventive, to all sections of the population. Special health services for mothers and infants and for school children, in other countries were started at different times and under different administrative authorities and the question of co-ordinating their activities and of bringing them together as parts of a general health organisation could not be considered in the absence of a comprehensive national health service embracing both the remedial and preventive aspects of medical practice. We may, as an illustration, make a reference to England and shall confine ourselves to the question of the school health service. In that country, the Board of Education (or the Ministry of Education) acquired powers in 1907 to make provision for the medical inspection and treatment of school children through the local authorities entrusted with the task of controlling education. The idea underlying such provision for the supervision of the health of the school child by the education authority was that the child's health should be protected in order to enable him to benefit fully from his education. The fact that the care bestowed on the child through his school life was but a part of the continuous health protection he was entitled to receive throughout his life was lost sight of. In consequence, the provision of medical care for school children became recognised as the responsibility of the education authority and not of the health authority. This position was modified by the Ministry of Health Act in 1919 when it was provided that "all the powers and duties of the Board of Education, with respect to medical inspection and treatment of children and young persons", should be transferred to the Ministry of Health. At the same time, it was decided that the Minister of Health, while retaining the ultimate right to determine the standards to be adopted from time to time in regard to the character, adequacy and efficiency of the provision made for medical inspection and treatment, should transfer to the Board of Education, his responsibility for the administration of the school health services. Nevertheless, in order to secure co-ordination of effort between the school medical and general health services, it has been the practice to make the Chief Medical Officer of the Ministry of Health the Chief Medical Officer of the Board of Education also and, in local areas, to appoint sub-committees of education and health authorities to consider matters of mutual concern, to administer joint undertakings, to appoint a common staff so that, in the great majority of cases, the local Medical Officer of Health is also the School Medical Officer, and to promote the use



of the same premises, wherever possible, and of common facilities such as the services of dentists.

### **The Present Position in India**

2. In India, school health services are non-existent in most parts of the country and, where they exist, they are mainly in an imperfectly developed state. There are, however, two valuable reports on the subject which provide an illuminating study of the associated problems and put forward specific recommendations for their solution. A report issued by a Joint Committee of the Central Advisory Boards of Education and of Health has dealt with this subject in great detail. The recommendations set forth in this report have been given practical shape in the Report on Post-war Educational Development in India which was issued by the Central Advisory Board of Education in 1944. In putting forward its proposals for the organisation and administration of school health services, the Joint Committee had before it, as a model, the practice in England which has already been briefly indicated in this chapter. It had also to accept the existing health administrative system in India whereby the medical and public health departments are functioning independently in the provinces. The Committee did not visualise the possibility of a comprehensive health service which would combine in itself both preventive and curative health functions for all sections of the community. In these circumstances, it recommended the creation and maintenance of a school health service which would be separate from the existing provincial health services, preventive and curative, and which would be under the administrative control of the Education Department. Recruitment to the school health service would be from the provincial medical and public health departments. In order to promote the co-ordination of the activities of the school health service and of those of the existing health departments, the Joint-Committee suggested the establishment of a Sub-committee with the Director of Public Instruction and the heads of the Medical and Public Health departments as members. Another suggestion was that, either of these two medical officers, as may be found expedient by the Provincial Government concerned, might be made the Chief Medical Officer of the School Health Service.

### **The Health Functions of the School Health Service to be under the Health and not under the Education Department**

3. In view of the reasons set forth in the earlier paragraphs of this chapter and in view of our proposal for the establishment of a comprehensive national health service, which combines within itself preventive and curative health functions, we believe that the suggestions of the Joint Committee referred to above require modification. We feel that, in England, the existing practice is a compromise based on the experience of the past development of the school health service in that country. In proposing a scheme for India, where we are practically in the position of starting the organisation from the beginning, we believe it will be of advantage to recognise that the question should be considered primarily from the standpoint of the school child for whom the service is being provided. From his point of view, continuity of health protection is of fundamental importance. Such continuity requires that the provision of medical care for school children should not be isolated from the general health service. Another important objection to the development of the school health

service, outside the general health organisation, is that a duplication of trained personnel and of institutions will become inevitable in many directions while, in the interests of the development of the national health programme, it seems essential that such duplication should be avoided as far as possible. We are, therefore, incorporating this principle in the proposals we put forward later in this chapter. We recognise, at the same time, the need for the closest possible co-operation between the medical officer and the school teacher in promoting the health and general welfare of the school child. The teacher will, indeed, play an important part even in the organisation of preventive and curative medical care for the child in the early stages of our programme, while his services are indispensable at any stage in connection with certain other forms of school health activity. Our proposals will, therefore, make provision for close co-operation between the health and education staffs.

### **The Functions of a School Health Service**

4. The duties to be performed by a school health service fall broadly into two groups:

(1) health measures, preventive and curative, which include (a) the detection and treatment of defects and (b) the creation and maintenance of a hygienic environment in and around the school, and

(2) measures for promoting positive health which should include (a) the provision of supplementary food to improve the nutritional state of the child, (b) physical culture through games, sports and gymnastic exercises and through corporate recreational activities and (c) health education through formal instruction and the practice of the hygienic mode of life.

5. The duties enumerated under (1) should be performed by the health organisation while those under (2) will devolve on the school teachers. This classification indicates broadly the division of functions between the health organisation and the school staff in a well-developed school health service although, as has already been pointed out, the utilisation of the services of the school teacher, with such training as can be given to him, will be essential, in the early stages, even for the carrying out of elementary preventive and curative health measures.

### **OUR PROPOSALS**

6. It seems to us inadvisable to start the school health service on too extensive a scale during the early stages of our health development programme. We believe that it is much better to develop the organisation with care and by stages so as to ensure satisfactory results rather than attempt too much in the beginning and thus court the possibility of failure. In making this suggestion, we have been influenced by two considerations, namely (1) the medical officer in the primary unit has various other duties to perform and he will, therefore, be able to devote only a limited time to the development of the school health service, and (2) the school teachers, who will have to carry out certain health duties, will require careful training and continuous supervision if the efficient functioning of the organisation is to be ensured. Finally, we would point out that the Joint Committee of the Central Advisory Boards of Education and of Health has drawn attention to the frequency with which Provincial Governments have, in the past, started a system of school medical

inspection and given it up after a short time. We wish to see that such a policy is avoided in the future and we would, therefore, urge the need for formulating a well-thought-out scheme capable of producing demonstrable results, even though it may embrace only a limited section of the school population in the early stages of development.

7. We shall first make certain general suggestions regarding the proposed school health organisation and then indicate the stages for its development.

(1) In each primary unit the male medical officer should normally be placed in charge of the school health service. It will be recalled that the woman doctor will, in addition to her responsibility for extending, as widely as possible, medical care among the women in the primary unit, have also to undertake the organisation and control of the maternity and child-welfare service. We, therefore, suggest that the male doctor should be responsible for the school health service.

(2) The scheme should, in the beginning, be restricted to primary school children. We anticipate that in accordance with the recommendations that have been made for post-war educational development, compulsory education will be introduced in respect of all children between the ages 6 and 13. Of this period the primary school stage is between 6 and 11 years. On a rough estimate, the number of children in this age group in a primary unit with a population of 40,000 is likely to be about 5,100. The Joint Committee has suggested that the number of school children to be entrusted to a full-time school medical officer might be about 5,000. In view of the other duties which our school medical officer will have to perform, we believe that the number of children to be included in the scheme in each primary unit should not, in any case, exceed 1,000. In order to facilitate frequent and close inspection of the work of the teachers who carry out health duties, we would suggest that the primary schools included in the scheme may be restricted to the town or village which forms the headquarters of the primary unit. If the population of school children thus served does not approximate 1,000, the scheme may be extended to the surrounding area, it being kept in view that such expansion should not make it difficult for the medical officer to carry out adequate supervision over the whole organisation. This is the primary consideration and not the idea that the number of children included in the scheme should be about a thousand.

Our proposal that, in the early stages, the scheme should be limited to primary school children will, it is believed, remove any objections that might, otherwise, be raised against the suggestion that the male doctor should examine school children of both sexes. When the high school and college classes are included in the scheme, a woman doctor will obviously be required for examining women students.

(8) From each school, at least two teachers should receive training in health duties. They should be given a special additional remuneration for such duties and Rs. 10 per month would be a reasonable figure for adoption throughout the country.

8. We suggest the following stages for the development of the scheme:—

### **First Stage**

It seems to us desirable that the proposed school health organisation should first be developed in an area close to the headquarters of the province. The field training centre, which will be established in association with the medical college there, will provide excellent facilities for such an experiment. The Department of Preventive Medicine and Public Health in the college can be placed in charge of it while the participation of the Director of Health Services, the Director of Public Instruction and their assistants in the development of the scheme will be of great value. It is suggested that the Professor of Preventive Medicine, the Assistant Director of Health Services in charge of school health and a suitable officer deputed by the Director of Public Instruction should form a small sub-committee to work out the details of the programme and to supervise its implementation.

The scheme should help—

(1) to demonstrate the course of training to be adopted for teachers;

(2) to develop the technique of school health administration, including the duties to be performed by the different members of the organisation, to keep records and to define the manner in which the health functions are to be integrated with other aspects of the programme such as health education and recreational activities. While the teacher has an important part to play in the provision of medical care, the health staff can, as will be shown later, assist in the development of those activities which are mainly the concern of teachers and

(3) to indicate the probable cost of such a scheme.

The organisation will also provide facilities for training doctors and nurses in school health work.

It is believed that this stage will probably be completed in one year. During this period the school health programme need not be extended over all the primary units of the field training centre. It is suggested that it may be confined to five such units.

### **The Second Stage**

This would mark the period of extension of the school health programme to the districts. Such extension may, it is suggested, be carried out in two steps. The first would be the organisation of training facilities for teachers at the headquarters of the secondary unit, namely, the secondary health centre. The Deputy Administrative Medical Officer should be made responsible for school health work. Such officers from the different districts should be given an opportunity to study the working of the scheme at the provincial headquarters and, with such study and with suitable literature indicating the detailed working of the programme, it should be possible to promote the development of district activities in this field on fairly uniform lines. The secondary health centre will normally be located in a large town, and the training course can be started by bringing together two teachers from each of the primary schools in that town. When a sufficiently large number of teachers is trained, a demonstration of the scheme should be attempted by applying it to this town

At the same time, the training course should be continued, selected teachers from a certain number of primary units included in the secondary unit, being brought over to the headquarters of the latter for such training. The medical officers of these primary units should also be given an opportunity to familiarise themselves with the organisation and maintenance of the service. The second step in the extension of the scheme in the district will be the inauguration of the service at the headquarters of individual primary units.

### Two More Stages

We envisage two more stages. These constitute extensions of the scheme so as to include within its scope (1) the whole area of individual primary units and (2) the students of secondary and high schools and of colleges. For reasons, which will be explained later, we cannot at present see how provision for a territorial expansion of the service in primary units can be made till about the latter part of the fourth quinquennium of our health programme. The first essential is to extend the proposed general health service throughout the area of individual districts, and this will take up at least the first seventeen or eighteen years of the programme and to require all the trained medical staff likely to be made available during the period. As regards the second of these two stages mentioned above, we are putting forward certain suggestions later in this chapter.

9. We may now present, in greater detail, our views regarding the nature and scope of the school health work that should be developed at the headquarters of primary units.

### School Health Work in a Primary Unit

10. The school health work to be carried out in a primary unit may be considered under the following heads:—

- (1) Medical inspection.
- (2) Provision of medical care, curative and preventive. Such medical care should include domiciliary and institutional service. It should also include dental service.
- (3) Improvement of environmental hygiene.
- (4) Improvement of the nutrition of the child.
- (5) Physical education.
- (6) Health education.

11. (1) *Medical Inspection.*—The Joint Committee recommended two detailed medical examinations for primary school children, the first in the sixth year of the child, as soon as possible after his entry into the school and the second in the eleventh year when the primary school stage is being completed. The Committee has pointed out, at the same time, that these detailed inspections should be supplemented, in respect of some children, by more frequent medical examinations. Such children include those who are found defective at the first examination as well as those who may be found by parents or teachers not to be making satisfactory progress physically, mentally or socially. While it is true that a careful parent or teacher can detect departures from normality, which a cursory medical examination may fail to reveal, the extent to which parents and teachers can help in such detection will depend largely on the degree to which

their faculty of intelligent observation has been developed. We shall make later in this chapter, certain suggestions for encouraging parents and teachers to play their part satisfactorily in the school health programme. In view, however, of the limited nature of the staff and facilities available to us, the recommendation of the Joint Committee for only two detailed examinations of every pupil should be accepted.

12. (2) *Provision of medical care, curative and preventive.*—The normal health services, remedial and preventive, which will be established under our scheme will, of course, be available to school children also. The dispensary and the domiciliary visits by the doctor and the nurse constitute the main provision for this purpose in the primary unit. The fact that the medical officer will himself carry on work at the dispensary three mornings a week and that he can secure the services of the nurse, whenever necessary, to visit the homes of pupils should help to ensure that the measures that he prescribes as the school medical officer in respect of individual pupils will be carried out as far as circumstances permit. Where a patient requires higher types of service, such facilities as are available at the 80-bed hospital and the secondary health centre hospital, can also be secured. But we desire to see these provisions supplemented by more specific measures calculated to improve the health of the school child, and the following recommendations are made with this end in view.

13. In the last chapter, when dealing with special health services for mothers and children, we described briefly the part that a maternity and child welfare centre can play in promoting health work among them. On the same lines, we suggest that a school clinic should be established as part of the programme of health care for school children. It is suggested that, in the beginning, the clinic should hold sessions in the dispensary on three afternoons each month. In view of the inadequacy of the provision for general medical treatment in the early stages of our health programme, the school clinic will have to devote a part of its time to such treatment. Nevertheless, too much time should not be taken up by such routine services. Certain specialised types of service, such as dental care and the treatment of conditions relating to the eye, ear, nose and throat, which are relatively common among children, should receive special attention. As regards dental service, we have already pointed out, in our description of the short-term programme, that mobile dental units, based on the secondary health units, will operate in the primary units and will make available such service at least to limited sections of the population. Maternity and child welfare organisations and school clinics will receive dental service from such mobile units.

14. It is desirable that the parents and the class teacher in charge of the child should be encouraged to be present at the clinic when examinations are carried out. This will enable the doctor to issue such instructions, as he may consider necessary, to enable them to take simple precautionary measures or to observe the child and report on the progress he makes or any setback that may take place.

15. Apart from the treatment facilities provided at the clinic a certain amount of routine treatment will also be carried out in the school, under the guidance and supervision of the medical officer, by the two teachers who will have been specially trained for this purpose.

Other functions for which these teachers are to be trained should include the daily examination of school children in order to improve the standard of personal cleanliness, supervision of the sanitation of the school and its environment and health education of children within limited fields. The teacher should also be trained in the technique of vaccination against smallpox.

16. A record of weights, taken at periodical intervals, gives valuable aid in interpreting the state of health of a child, and each class teacher should be made responsible for maintaining this record and for making it available to the medical officer once in six months.

17. As in the case of the maternity and child-welfare centre, we desire to see that the school clinic develops into an organisation for bringing together the children, their parents and teachers. We would, therefore, suggest that periodical meetings should be arranged for which interesting and educative programmes should be developed. Educational films can be shown, short talks on health matters arranged and people with special talent for music and other forms of entertainment, whether among the pupils, teachers or parents, encouraged to play their part towards making such gatherings a success. The atmosphere of goodwill that can thus be developed will be of advantage to all concerned.

18. We are anxious that all teachers should take an active interest in our school health programme. Although the two who are specially trained to carry out certain health duties, will be required to do more than the others, we feel that every one of them has his part to play. For instance, the class teacher can, if observant, bring to notice facts about a boy's indifferent health or anti-social tendencies more easily than the other teachers are likely to do. The physical instructor should be able to separate, by signs of early fatigue or in other ways, children to whom the normal amount of exercise prescribed for all is doing more harm than good. These teachers, if they can receive useful hints from the doctor, will undoubtedly be able to discharge more efficiently the duties expected of them.

19. As regards the parents, theirs is the longest and most sustained influence on the health and welfare of the child. Any scheme that neglects to enlist the sympathy and co-operation of the parents may largely fail to achieve the desired results. Our proposal to make the school clinic a centre for social activity so as to bring together the children, parents, teachers and the school health staff is, therefore, in our view, an essential part of the programme for improving the health of the school child.

20. We fully realise that the present-day school teacher, ill-paid and overburdened as he is with responsibilities towards his own family which he can hardly discharge satisfactorily, is but an imperfect instrument through which to attempt to develop a programme of health activity on the lines we have indicated. We have, however, no choice in the matter and would, therefore, suggest that in selecting teachers to perform the health duties contemplated in our scheme, the greatest possible care should be exercised to ensure that the two best in each school are chosen. The training that is imparted, the additional remuneration we propose and the close and continuous supervision which will be exercised should all help to secure a reasonable measure of efficiency. But our hope for the future is based on the prospect of a better class of school teacher

being provided as the result of post-war educational developments. It is hoped that he will have received a higher standard of general education, will be better paid and will be actuated by a more quickened sense of social service than the teacher of the present day. It is on him that we pin our faith for the development of a co-operative effort to which the school staff and the health organisation will contribute of their best in order to promote the health and welfare of the school child.

21. (3) *Improvement of environmental hygiene.*—This is a problem of the highest importance. Many school buildings will require considerable alterations before they become satisfactory from the sanitary point of view. Wholesome drinking water, sufficient toilet accommodation, and facilities for washing will all have to be provided if the desired improvement in the hygienic habits of the pupils is to be promoted. To give formal class room instruction regarding cleanliness, without providing the necessary facilities for the children to put into practice what they are taught, is worse than useless. Apart from the harm it causes by failing to give the child proper instruction in the hygienic mode of life, such a divorce of practice from precept will have a serious detrimental effect on the outlook of the growing child. We feel that this is a matter which requires urgent attention from the authorities concerned.

22. (4) *Improvement of the nutrition of the child.*—A mid-day meal providing a balanced diet, in accordance with modern conceptions of desirable nutritional standards, will perhaps help to improve the health of the growing school child to a greater extent than most other measures. Many children, especially in the rural areas, walk distances of two or more miles to their schools and back home every day. With such physical exertion in addition to any games and other forms of athletics in which they may take part, it is not surprising that, even from the point of view of energy value, many children do not receive an adequate amount of food. Moreover, as a sufficient quantity of essential articles such as milk and green leafy vegetables are often lacking in the food of an appreciable proportion of these children, there is the added disadvantage of living continually on an ill-balanced diet. The provision of a good mid-day meal at the school should help to rectify these defects to a large extent, and we recommend that it should be a compulsory feature of the school health programme. While there is no doubt some justification for claiming that the State should not be made to pay for children, whose parents can afford to meet the necessary expense, we feel that, if primary education is to be made compulsory and free to all in accordance with the recommendation of the Central Advisory Board of Education, the additional cost for the school meal should also be made a charge on the public funds. Those who can afford to pay will, of course, be contributing to public funds through local and provincial taxation. But we are not wedded to any specific form of raising money to meet the expenditure on school meals. We would only urge that the provision of a balanced mid-day meal, of proper quantity and quality, to all school children should form an essential part of the school health programme.

23. (5) *Physical education.*—We have discussed the question of organising the physical education of school children in the chapter dealing with that subject and shall, therefore, confine ourselves here to



the consideration of the subject in relation to the school health programme. We are in full agreement with the view of the Joint Committee that the physical instructor should receive training "in the elementary principles of physiology, of the hygienic mode of life and of nutrition" and that he should be trained "to detect early signs of fatigue in the child and to regulate (under the guidance of a doctor in certain cases) the nature and amount of exercise for individual pupils". The doctor should give, as the result of his medical examination, any special instructions regarding physical exercise that may be required in respect of individual students. The physical instructor should, on his part, bring to the notice of the doctor any cases where he has reason to believe that exercise should be regulated in accordance with medical advice and he should be present when such children are examined by the doctor.

24. We also endorse the recommendation of the Joint Committee that provincial Health and Education authorities should draw up a code on physical education, which should include advice on the medical aspects of this subject, and that a system of graduated exercises, to suit the requirements of different types of children, should be formulated.

25. (6) *Health education*.—Formal class room instruction in health matters should, in respect of the primary school children, be reduced to the minimum. What is essential is that hygienic habits should be inculcated. A health parade every morning to ensure that each child conforms to certain standards of personal cleanliness is of great value. In the school, children can be taught by observant and sympathetic teachers to rectify many of the undesirable habits they have developed. For instance, spitting can be discouraged, the intelligent use of the sanitary conveniences provided in the school premises can be encouraged, the necessity for avoiding possible infection of neighbours through coughing and sneezing without due care can be brought home to the children and the danger of catching infection through infected food and water can be vividly described to them if specific instances based on local occurrences can be quoted. As has already been pointed out, an essential part of this health education campaign is that the school and its surroundings must be kept in a hygienic condition and that all the necessary facilities should be provided to enable the children to carry out the instructions given to them regarding cleanliness.

26. As regards formal instruction, the spoken word and the visual impression are more important in the case of such young children than printed literature. Therefore, short talks accompanied by coloured posters or magic lantern shows are much better than books. In regard to personal hygiene, repeated performance by the pupils of the necessary measures under the supervision of the teacher is essential. The example set by the latter is also of great importance because a teacher, who flagrantly violates the instructions he gives, will carry no influence with the children. The remedy lies in the systematic teaching of hygiene in teachers' training schools. But we believe that a marked improvement in the present situation will be seen only when a better class of teachers, with a higher standard of

training and better emoluments, becomes available as the result of the post-war educational programme.

### **An Extension of the Health Service beyond the Primary School Stage**

27. We anticipate that, under the programme of development of the school health service indicated earlier in this chapter, the organisation at the provincial headquarters and those associated with the headquarters of secondary units, will become centres for providing short courses of training in school health work to doctors and nurses. We have suggested that, at the early stage, the school health service should confine itself practically to the headquarters of the primary unit. Even so, it will probably take the first five years of our short-term programme before such an organisation becomes established and works satisfactorily in every primary unit under the scheme.

28. A point for consideration is whether the service should, at this stage, be extended further into the area covered by individual primary units or whether it should be expanded so as to include gradually the students of the secondary and high schools and college classes. The main obstacle to an extension of the scheme territorially in a primary unit is the inadequacy of trained staff. This deficiency will not be made up in the second quinquennium of the short-term programme, because our plan is that such staff of all types, as may be created under the various training schemes, should be utilised for the opening of new primary units, and that the general health organisation should be extended to about half the population of each district by the end of the first ten years. No strengthening of the staff in individual primary units is contemplated at this stage. If the implementation of all our proposals proceeds on anticipated lines, the third and fourth quinquennia should witness the rate of progress accelerated inasmuch as the large scale training programme of the first ten years would have begun to bear fruit. Nevertheless, we find it difficult to believe that individual districts will be covered by the health organisation before the end of the first 17 or 18 years of our programme. It is only after this stage is reached that a strengthening of individual primary units by additional staff should be undertaken. Therefore, as far as we can see, the possibility of expanding the school health service for primary school children, much beyond the limits of the headquarters of each unit before the end of the first 17 or 18 years, seems to us to be remote.

29. In these circumstances, there would appear to be little hope of extending the service, within this period, to the students of secondary and high schools and of colleges particularly on any large scale. We would, however, suggest for consideration the possibility of such extension in certain limited areas where suitable conditions will probably be available by the latter half of the second quinquennium of our health development programme. We have, in mind, the field training centres attached to individual medical colleges. These will normally be located in the larger cities of a province, and the resources of the local health organisation supplemented by those of the medical college may justify an attempt to extend the school health service to, at least, the students of secondary and high schools in such cities. The primary consideration should be that the organisation must function on sound lines and, wherever this condition can be fulfilled, an extension of the service should be attempted. By the time this experiment has been tried, it may well

be that many of the secondary health centres will also have developed to the stage when they can undertake such an extension of the school health service. The administrative and technical procedure for the expanded service which will, in the meantime, have been worked out in the training centres associated with medical colleges will prove to be of assistance to the secondary units in expanding their school health services.

### **Co-operation between Health and Education Authorities**

80. In the preceding paragraphs, we have discussed our recommendations for developing a school health programme and, at more than one place, have stressed the need for the closest co-operation between the health and educational authorities. We now set forward certain proposals for ensuring such co-operation both locally and centrally.

31. *A District.*—If our suggestions for the future development of local self-governing institutions are carried out, there will be a District Health Board and a District Education Board functioning over practically the whole area of individual districts. We suggest that, in each district, a Joint Committee of the District Health and District Education Boards should be established. The funds necessary for the health activities of the school health programme will be a charge on the revenues of the District Health Board, while the cost of such items as physical education, school meals and health education should be met from the funds of the District Education Board. The remuneration to be paid to the two teachers in each school for the health duties they perform should, of course, be met from the health budget. The Joint Committee we have recommended will be responsible for the distribution of the funds made available to it by the two Boards and will also serve to bring the influence of public opinion to bear on the working of the school health organisation.

32. *Provincial Headquarters.*—At the headquarters of the province, there should be a co-ordinating committee of which the Director of Public Instruction and the Director of the Health Services should be members. Its chairman may be a distinguished educationist. We do not wish to see this co-ordinating committee at the provincial headquarters made unduly large, but representatives of the managements of private schools as well as of approved associations of teachers and of parents should, in our view, find a place on it.

33. This committee will advise Government on all matters relating to school health administration, including the distribution of grants-in-aid, and, within the limits of the powers given to it by Government, it will co-ordinate the activities of the Joint Committees in the districts.

34. As regards the administrative staff on both sides (of health and education), the members of the health organisation will belong to provincial cadres in the Health Department of the province. The Co-ordination Committee at the headquarters of the province should, in these circumstances, be able to ensure that the desired measure of co-operation between the health and educational staff is secured in order to promote the development of the school health service on sound lines.

## CHAPTER X

# OCCUPATIONAL HEALTH INCLUDING INDUSTRIAL HEALTH

### Introduction

1. In this chapter we shall deal with the questions relating to the maintenance of the health and working capacity of all those who are gainfully employed outside their homes. We have purposely used the term 'Occupational health' in the title of this chapter because many forms of employment fall outside the range of activities normally included under the term 'Industry'. For instance, the working conditions of the employees, including the sanitation of the environment, hours of work and provision of certain facilities such as for meals and rest, require regulation in a public office or a large shop to the same extent as in an industrial establishment. Further, similar protection should be given to workers in the building trade and to those employed in transport by land, sea or air and in various other occupations, although such workers are not normally included under the term industrial labour. Lastly, agriculture which is the main occupation in the country and has associated with it the largest population of workers, should come within the range of health supervision in order to ensure that conditions unfavourable to health are eliminated as far as possible from the working environment of this section of the population also. An occupational health service developed by the State should therefore, embrace, within its scope, all persons who are employed outside their own homes. We realise, however, that the creation of such a service can be considered only as a long-term objective and that, in the immediate future, Governments will have to concern themselves with measures mainly for industrial workers including within that term those who are employed in factories, docks, mines, plantations, transport services and certain other occupations. While it seems desirable to keep in view the goal that has to be reached and to remember that the provision of conditions favourable to health should be an essential part of the organisation of all types of employment, we shall deal here only with the health of industrial workers as defined above.

2. The factors which influence the health of the worker can be divided into two broad groups, namely, (1) those which are associated with his working environment and (2) those which he shares with the rest of the community in the home and in the places of public resort to which he usually has access. In regard to the latter, it seems reasonable to hold that the workers should share the facilities for health protection that the State provides for the general population and this is what we recommend.

3. On the other hand, as regards the factors in the working environment which tend to produce ill-health, the worker has the right to demand special measures for his protection. The organisation of an industrial health service is meant to meet this need. The aims of such a service should be twofold, namely, that of minimising, as far as possible, the detrimental effects associated with the worker's occupation as well as that of promoting measures which are designed to create optimum working conditions and to increase his capacity for work and general sense of well-being. If this dual aspect of the

worker's health requirements be kept in mind, it will become clear that the provision of preventive and curative health care outside the place of work or for general ailments, which may arise without reference to his occupation cannot be considered as the responsibility of the industrial health organisation. It is recognised that sickness and incapacitation arising out of any cause have their repercussion on occupational efficiency and that these are therefore to be eliminated as far as possible. From this wider standpoint the provision of adequate health protection to the members of a worker's family can also be considered as an essential function of the industrial health service, in as much as the worry, anxiety and their adverse effect on his own health, which are likely to arise from sickness among those who are dependent on him, must reduce his working capacity. While recognising the force of this argument, it is believed that clarity in respect of administrative procedure will be secured by accepting the position that the responsibility for the health of the worker outside the range of functions of the industrial health service as defined above as well as for the health of the members of his family must devolve on the general health service for the community and that, in the interests of the nation as a whole, both types of services must be developed to the fullest possible extent.

#### **The Aims of an Industrial Health Service**

4. The aims of an industrial health service have been excellently described by the Social and Preventive Medicine Committee of the Royal College of Physicians of London in their Second Interim Report, which deals with industrial medicine, (January 1945) in the following terms:—

- “(a) to promote the general health of the worker by the provision of a good working environment and by fitting the worker to that environment;
- (b) to prevent occupational disease;
- (c) to assist in the prevention of injuries at work;
- (d) to organise and supervise a service for the emergency treatment and care of injured and sick workers at their place of work;
- (e) to take an active part in the restoration to full working capacity of workers disabled by injury or disease and resettlement of workers suffering from permanent disability;
- (f) to educate workers in the preservation of health and promotion of well-being and
- (g) to promote research and investigation.”

5. This comprehensive statement of the functions of an industrial health service may be accepted as the objective to be aimed at, in this country, when the development of such an organisation is undertaken. It will be seen that the health protection that will be offered will be largely preventive in character. At the same time, provision will be made “for the emergency treatment and care of injured and sick workers at their place of work” as well as for the rehabilitation of those whose working capacity has been affected by injury or disease. The education of the worker in the preservation of his own health, with particular reference to the hazards of his occupation, is an essential function of this health service, while the promotion of

research and investigation into occupational health problems is fundamental to the proper functioning of the organisation and to a progressive expansion of its activities.

6. We may, with advantage, describe briefly the proposals of the Committee for the industrial health service that has been recommended by it for England. As regards its organisation, the Report recommends that "the industrial health service should be an integral part of the proposed national health service and should be administered centrally by the Ministry of Health. Certain administrative and executive functions will, no doubt, require to be delegated to the Ministry of Labour and National Service and other bodies in order to maintain contact with the lay inspectorate, but it would be desirable for the Chief Medical Officer of the Ministry of Health to hold the same position in this regard in the industrial health service as he does in relation to the Ministry of Education."

7. It may be explained here that, while the Minister of Health is in England responsible for the health of school children, he has appropriated to himself only the power of determining standards and has transferred to the Ministry of Education the administration of the school health service. At the same time, in order to ensure co-ordination between this organisation and the general health service, the Chief Medical Officer of the Ministry of Health has been made *ex-officio* the Chief Medical Officer of the Ministry of Education.

8. The work of the industrial organisation should be integrated with the work of the general health services in each local area under the national health scheme, "including those provided by the general practitioners, the hospitals and any specialised units which are available for the treatment of occupational diseases and research and teaching in this subject." A brief reference to this national health service in Great Britain has been made in the chapter dealing with modern trends.

9. The industrial health service will consist of medical and non-medical personnel. The former will include a medical inspectorate associated with central and regional administration, consultants in industrial medicine with "in-patient facilities at selected hospitals with beds under the charge of the consultants", whole-time industrial medical officers serving one industrial establishment or a group of them under one firm or a group of firms and part-time industrial medical officers, who will be general practitioners with special training in industrial medicine. The non-medical personnel will include industrial nurses, social workers, welfare workers and certain technical specialists.

10. The report emphasises the importance of establishing Departments of Industrial Health in the teaching medical institutions of the universities. They "should be charged with fundamental research, including field investigation, especially in relation to problems of their own region." These University Departments of Industrial Health will also play an important part in the training of industrial medical personnel, including consultants and specialists in industrial medicine.

11. It will be seen that the aims of the industrial health service in that country as suggested by the Committee of the Royal College of Physicians do not include the provision of general medical aid to the industrial population. That function will be performed by the national health service with which the industrial health organisation

will be integrated. The objects to be achieved through the latter are, in the words of the report, "the promotion of the general health of the worker by the provision of optimum environmental conditions and by fitting the worker into such conditions; the prevention of disease and accidents in industry; the taking of an appropriate share in the rehabilitation of the disabled workmen; and the education of the workers in the preservation of health and promotion of well-being."

12. These proposals of the Social and Preventive Medicine Committee of the Royal College of Physicians provide useful suggestions for the organisation of an efficient industrial health service in India. Such a service must obviously be complementary to a well-developed general health service for the community as a whole because, as has already been pointed out, the worker, in addition to the protection he requires against the hazards to health that arise out of his occupation, must be cared for as a member of the general population among whom he lives for the greater part of each day of his life. As has been proposed for England by the Government of that country, we have recommended, in this report, the development of a comprehensive health service which will provide a reasonable measure of curative and preventive care to all sections of the population in India. It is essential that our proposals for an industrial health service should fit in with this scheme of general health protection for the community. The adoption by us of the aims and structure of the industrial health organisation, as set out by the Committee of the Royal College of Physicians, seems, therefore, to be appropriate. The creation of centres of teaching and research in industrial health in the medical colleges attached to the universities will be necessary before such an organisation can be developed to any considerable extent in India. Further, the hospitals and the consultant and laboratory services that our general health service will provide will also be necessary for the proper functioning of the proposed industrial health organisation.

This does not mean that a beginning should not be made at once with such facilities as may be available.

13. In our recommendations for the development of the future health programme, we have accepted the present position whereby the main health functions for the community are the responsibility of Provincial Governments. We, therefore, suggest that the industrial health organisation should form an integral part of the Provincial Health Department and that it should work in close association with the Provincial general health service. We may state here that we arrived at this decision independently and before we had the opportunity of becoming acquainted with the recommendation of the Committee of the Royal College of Physicians in this behalf.

14. The proposed industrial health service will not minister to the general medical needs of the industrial population. This function will have to be performed by the health service for the community as a whole. The latter is as yet in an undeveloped stage in the country and the implementation of our proposals, which will provide a reasonably satisfactory service, can be carried out only through a period of years and in stages. The view is held by some of us that the need for providing medical relief to the industrial population, on a higher scale than is at present available, is urgent. The industrial worker is generally a migrant from rural areas and lives and works

in a more congested and unhealthy environment than that to which he had been accustomed. He often lives separately from his family and exposed to the temptations that urban conditions provide. These facts, coupled with the share that he contributes to the wealth of the nation through the promotion of industrial development seem to lend some justification for asking that the State should contribute from the public funds towards the provision of special facilities for the medical relief of the industrial population, even in advance of the development of the general health programme. We gave full consideration to this question when we laid down, in the chapter dealing with modern trends, certain principles that should govern the development of health services. These are (1) that public funds should, as far as they are available, be devoted to the development of the health service which we have recommended for the community as a whole and not to the creation of special facilities for certain specific sections of the population; (2) that the cost of the latter services, if they are to be developed, should, until such time as they are absorbed in the general health services, be met by the communities or groups which will be benefited by such services and (3) that the general health service should minister to the needs of the people without payment of fees.

15. These principles should not, however, be held to preclude Governments from applying in advance any portion of the programme suggested by us, to certain areas or to particular groups of the population, if they consider this essential in the general interest. We realise that our programme cannot be carried out on all fronts simultaneously to exactly the same extent and that, therefore, advanced applications of parts of it may be necessitated by special considerations.

16. One of us (Mr. N. M. Joshi) desires to supplement the view expressed above by suggesting that Governments should not be precluded from making financial contributions to any scheme for industrial workers when undertaken by a statutory body. We quote his words, "I hold that, in case the Governments, while accepting the need for applying in advance any portion of the programme suggested by the Committee to any particular group of the population such as industrial workers, are not in a position actually to apply it in advance to that group, the Governments will not be considered to be precluded from making financial contributions to any scheme undertaken by any statutory body."

17. We have already recommended that the general health service for the community should be given to all free of charge. Should the proposed industrial health service be offered on the same basis or on payment? In reaching a decision on this point it should be remembered that the health protection that will be offered will be largely preventive in character, although provision for treatment and rehabilitation will also be made in order to meet situations in which prevention fails. In these circumstances it seems doubtful whether the worker can reasonably be charged for such services. It is for consideration whether the employer should not be made to contribute towards the service. It is undoubtedly in his interests to keep down absenteeism through sickness to the lowest possible level and to improve the general health and productive capacity of the workers. The demand for a contribution from the employer towards the proposed industrial health service does not seem unreasonable. We, therefore,



suggest that the employer and government should together be responsible for meeting the cost of the proposed industrial health service and that the worker should be exempt from being made to pay for it.

18. We understand that the creation of a central health insurance fund, which will be raised by contributions from Government, employers and workers and will be utilised for the benefit of the workers, is under contemplation. If the proposed central fund comes into existence it should be possible, by grants from it, to promote the development of an even higher level of general health service for industrial workers than that envisaged under our short term scheme for the community. Further grants from this fund, if available, could be utilised for establishing an industrial health organisation on the lines indicated in this chapter, thus providing the two types of complementary health services which the worker requires.

19. It may be asked whether the financing of this service from the central fund will not constitute a compulsory contribution from the workers towards the industrial health organisation. It will be so to a limited extent. We presume that the major proportion of their contribution will, however, go back to them as cash benefit during periods of sickness. In the early stages of development the financing of the industrial health service by the central fund appears to us to afford a practical method of ensuring that the organisation is brought into existence. As a long term measure we envisage that the State will bear, in the first instance, the whole cost of the scheme and then recover from employers such proportion of it as may be laid down by law.

#### **Certain other Recommendations for Early Action.**

20. While these proposals for an industrial health service will obviously take time to materialise, we desire to put forward certain recommendations for early consideration and appropriate action by Governments. These recommendations are based on our study of the industrial health problem through visits to industrial establishments in different parts of the country and through interviews with employers, workers, Government officials concerned with industrial welfare and private individuals who are interested in the problem.

#### **Training in First-aid**

(1) All employers should encourage the organisation of first-aid training in their institutions. It is suggested that at least four persons out of every 150 workers should be trained in first-aid according to the standards laid down by the St. John Ambulance Association.

#### **Creches**

(2) (a) In industrial undertakings employing more than 50 women a statutory obligation should be laid upon the employer

(i) to provide suitable creches for the children of women workers under the supervision of trained family attendants, with adequate provision for washing and changing of clothes;

(ii) to supply free milk to the children and

(iii) to provide facilities for the women workers to feed their babies when necessary while on duty.

(b) In industries employing less than 50 women the obligation to provide creches, where their children can be cared for while their

mothers are at work, should be placed upon the local authority which is responsible for the health administration of that area. Such creches should be located in central places which are convenient for a number of industrial establishments.

### **Maternity Benefits**

(3) Maternity benefits should be granted to women workers in accordance with the recommendations of the International Labour Convention No. 3 of 1919 which recommends that women should be forbidden to work during a period of 6 weeks following their confinement, and that before confinement they should have the right to leave work and receive maternity benefits on the presentation of a medical certificate showing that they are likely to be confined in six weeks' time. During these periods she should be paid her full wages because it is just at this time she requires nourishing food and special treatment. The payment of full wages, moreover, is justified in India where the prevailing wages of women workers are, generally speaking, very low.

### **Employment of Women in Coal Mines**

(4) We are unanimously agreed that, from the point of view of health, it is undesirable that women should be employed underground in coal mines.

### **Hours of Work**

(5) (a) We are of the opinion that purely from the point of view of health of the workers, the maximum hours of work prescribed in the Factories and other Acts are too long and should be reduced. In view of the climatic conditions of the country, the frequent difficulties of transport to and from the worker's home, his poor physique and nutritional deficiencies, the necessity for a mid-day rest and his general social and economic environment, we recommend that the maximum should be reduced to 45 hours a week, i.e., 8 hours a day for 5 days, and 5 hours a day for one day, and that the Factories and other Acts be amended accordingly.

(b) In the case of seasonal factories, which may be obliged to work under considerable pressure during only a part of the year, this maximum may be increased after taking into account such relevant factors as the extent of hazard to health that the occupation involves and the distance that the workers have to walk back to their homes.

(c) We recommend an interval for the mid-day meal of not less than one hour, exclusive of working hours.

(d) We recommend that the maximum period during which workers are continuously on night duty should be limited by statute to a fortnight.

### **Accidents**

(6) (a) Compensation in respect of accidents should be payable to all notifiable accident cases from the first day of disablement and the seven days' waiting period should be abolished.

(b) We were struck by the fact there were no centres in industrial areas for the purpose of rehabilitating and retraining workers, who are unable to take up their original employment as the result of accidents. Provision should be made for the proper treatment and rehabilitation of injured persons so that they may recover and get back to work

as early as possible. There should also be provision for the supply of artificial limbs and eyes.

Adequate facilities for the treatment and rehabilitation of workers will become available only when the proposed industrial health service becomes established in addition to the general health service recommended by us, and we therefore stress the need for organising both these services in the larger industrial centres with the least possible delay.

(c) Another point to which we would draw attention is the unsatisfactory state of registers of sickness and injury among employees, particularly in the smaller industrial establishments. We recommend that proper registers of sickness and injury should be maintained in every industrial establishment in accordance with the standards prescribed by Provincial Governments.

### **Occupational Diseases**

(7) (a) There should be an enquiry by the Government of India as early as possible into the prevalence of occupational diseases in the country. As there are so few medical officers trained and experienced in this subject, we recommend that a number of them be sent abroad for further study in industrial hygiene and occupational diseases.

(b) On the completion of the enquiry referred to above an exhaustive list of occupational diseases in India should be prepared and all such diseases should be made notifiable by Statute.

(c) Departments of Industrial Medicine, the functions of which will include, among others, the study of occupational disease and industrial research, should be established in teaching medical institutions and we suggest that a start should be made at the All-India Institute of Hygiene and Public Health.

### **Women Doctors**

(8) An adequate number of women doctors should be employed in the proposed industrial health service.

### **Housing**

(9) (a) We have expressed in another chapter our opinion that the housing of the industrial population is primarily the responsibility of the Governments concerned. We have also made recommendations relating to the preparation of housing schemes for the population generally, including the industrial population, by Governments, local authorities and private enterprise. In this chapter we content ourselves with recommending the following minimum standards for working class housing, which Governments should prescribe and strictly enforce. We regard these standards to be the minimum required for the health of the industrial worker and his family:—

(i) For a single man: a room 10 ft. × 12 ft. × 10 ft. and a verandah 8 ft. × 8 ft. × 10 ft. For a group of such quarters there should be provided community kitchens, latrines and bathing places in accordance with the standards to be prescribed by the Provincial Government. Where common kitchens are not provided, provision should be made for *choolas* on the verandahs with suitable chimneys for the outlet of smoke. Where latrines and bathing places for common use are

erected, they should be at a reasonable distance from the quarters, and, if possible, connected by a covered way for protection during bad weather.

(ii) For a family: for a married couple, two rooms 10 ft. × 12 ft. × 10 ft. with a verandah, kitchen, bathroom and latrine. For a family including grown up children the accommodation should be increased by at least one extra room of similar size.

(b) In regard to sanitary conveniences, we suggest that, as far as possible, septic tank and soil distribution systems should be introduced so that the handling of nightsoil may be avoided.

### **Food of the Workers**

(10) (1) *Nutrition*.—(a) In our opinion no effective improvement in nutrition is possible unless purchasing power is increased. How this should be done is a question which does not properly come within our terms of reference but we consider it our duty to draw attention to this important matter.

(b) We recommend that systematic nutrition surveys should be undertaken by Provincial Governments in various industrial centres for the purpose of estimating existing levels of nutrition among the industrial classes. We have recommended, in Chapter V, that each Provincial Government should maintain a nutrition organisation as part of its Health Department. It should be one of the duties of this organisation to carry out the surveys suggested above, to formulate balanced diets to meet the energy and other requirements of different types of workers and to assist in the carrying out of educative work in nutrition among employers and employees.

(c) It should be compulsory, in the first instance, for industrial establishments employing a certain minimum number of workers to maintain canteens. These canteens should provide for workers suitable balanced diets at reasonable cost.

We recognise that the daily energy requirements of individual workers will vary with the amount of physical effort that they may be called upon to put forth. We recommend, however, that, when providing for balanced diets to workers, 3,000 calories daily may be adopted as the energy requirement of the average manual worker engaged in industry.

(d) Employers should encourage workers to observe regular meal hours. Rules regarding night shifts should be so framed as to allow workers to get adequate time for proper meals.

(e) Municipal bye-laws regarding the protection of food require strengthening and stricter enforcement. In order to secure adequate supervision there should be a sufficient staff of well-trained and well-paid sanitary inspectors under the control of the health authorities, who should have free access to the premises of any industrial establishment for ensuring cleanliness in the preparation and distribution of food.

(f) Every canteen, food shop, tea shop and kitchen in an industrial establishment should be protected against flies etc., by the provision of flyproof doors and windows.

(2) *Adulteration*.—There should be more stringent supervision over food supplies inside the factory areas by municipal authorities. We have recommended in chapter XXIII detailed measures, legislative and

administrative, for dealing with the problem of adulteration in respect of food for the general community, including industrial workers.

(3) *Hawkers*.—As far as possible hawkers should not be permitted within factory premises but, where canteens have not been provided, hawkers, when permitted inside a factory, should be licensed by the public health authority and the food offered for sale by them should be subject to examination and inspection by that authority.

(4) *Milk*.—In view of the importance of milk in the diet of the people we have recommended in the chapter on nutrition that special measures should be taken by Governments and local bodies, to ensure an adequate supply of this article of food to the community at prices within their reach. These measures will benefit industrial workers also. In addition we recommend that local authorities should, with the co-operation of employers and employees, promote the development of co-operative dairy farms or arrange for the supply of milk in other ways in order to improve the standard of milk consumption by workers.

### **The Zoning and Location of Industry**

(11) (a) Town and Rural Planning Acts should be passed by Provincial Legislatures setting up in each province a separate Ministry of Housing and Town and Rural Planning, with wide powers to deal with the housing of the industrial population and with the zoning and location of industry.

(b) Before the establishment of any new industry or factory is agreed to by the Provincial Government, the Minister should satisfy himself that, in the lay-out, adequate provision is made for the housing of workers, for their transport to and from the factory and for adequate environmental amenities.

(c) We wish strongly to reiterate the recommendation of the Royal Commission on Labour that Provincial Governments should take steps to prevent industries being established in places where there will not be sufficient room for adequate housing or other necessities such as water supply, electric power, etc. This should be the function of the Ministry of Housing and Town and Rural Planning if established, and, under the appropriate legislation, rules should be framed to regulate the growth of industries from this point of view.

(d) We commend for serious consideration the suggestion that, where possible, having regard of course to the relevant economic factors, new industries should be dispersed in rural areas so that the local inhabitants may derive the fullest benefit from industries being brought within their immediate circle. The present system of establishing factories near or in big towns, where the workers are forced to live in crowded tenements and under artificial and insanitary conditions as parts of a huge machine, is harmful alike to the town dwellers and the workers themselves. The health problem of workers in such industries would be greatly simplified if industrial establishments could be located in rural surroundings.

### **Drink and Drug Habits**

(12) (a) There should be stricter control over the licensing and location of liquor shops in industrial areas, the hours of opening, and closing, the quality of drinks sold and, in particular, the standard of cleanliness maintained in these shops.

(b) The aim should be to make places, where alcoholic beverages are permitted to be sold, decent establishments where a high standard of cleanliness is maintained and suitable refreshments are provided, so that a man can take his family and order food along with drinks. The experience in the West is that, under such conditions, the excessive consumption of alcohol is generally checked.

(c) The hours of sale of alcoholic drinks should be reduced.

(d) There should be strict control over the sale of opium, '*ganja*', '*charas*' and '*bhang*', in order to reduce their consumption by the industrial population as much as possible.

(e) The majority of us feel that the opening of new liquor shops in industrial areas should not be permitted. The others, while considering this to be too drastic a step, support the strictest possible restriction in the opening of new shops in such areas.

(f) In order to promote the consumption of non-alcoholic beverages we suggest that local authorities should afford all facilities for the opening of milk bars, tea and coffee shops in industrial areas.

### Transport

(13) In view of the utmost importance of the provision of cheap transport facilities for workers to and from their homes, we recommend that Provincial Governments and local bodies, with the co-operation of private enterprise, employers and co-operative organisations should take immediate steps to ensure the provision of such facilities.

### Industrial Hygiene and Conveniences for Workers

(14) All rules regarding industrial hygiene within factories, mines and other industrial establishments, such as those pertaining to ventilation, control of humidity, cooling, smoke nuisance, dust, water supply, provision of urinals and latrines, bathing arrangements, drainage, disposal of sewage and mosquito control should be re-examined and brought up-to-date by the Governments concerned. Steps should be taken to ensure their stricter enforcement.

The following suggestions are offered in respect of certain specific matters:

(i) *Control of humidity and temperature.*—The rules relating to the control of humidity and temperature in factories should be re-examined in consultation with the Provincial Health Department and steps should be taken to ensure that they are more rigidly followed.

(ii) *Air-conditioning.*—Under certain climatic conditions air-conditioning of industrial establishments is calculated to improve the health conditions and to promote a larger out-turn of work. We therefore recommend that, wherever possible, employers should be encouraged to instal air-conditioning plants.

(iii) *Protection against the inhalation of gas, dust or other impurities.*—Under section 14 of the Factories Act provision exists for requiring that, in any factory in which gas, dust or other impurity is generated, adequate measures shall be taken to prevent injury to the health of the workers. The same section also empowers Provincial Governments to make rules in this behalf. Where such rules have

not yet been issued, we recommend that Provincial Governments should frame and enforce them without delay. Existing provision relating to such measures should be more strictly enforced. Whether the factory be large or small, the provision and maintenance of mechanical or other devices for preventing the generation or inhalation of gas, dust or other impurities injurious to the health of workers are essential. In any event, in the smaller factories, masks should be provided for workers and they should be made to understand the evil effects of inhaling gas, dust or other impurities. Instructions in the use of such devices should be given.

(iv) *Smoke nuisance*.—In some Provinces, there is at present legislation relating to smoke nuisance, but its enforcement is not often effective. We recommend that the Government of India should institute an investigation into the dangers of smoke nuisance in industrial and other areas and that swift action should be taken on the recommendations arising out of such an investigation.

(v) *Washing facilities*.—There should be provision, in every industrial establishment, of washing facilities for all workers and, in the case of workers handling or coming into contact with obnoxious substances, there should be a free supply of soap or some other cleansing material.

(vi) *Drinking water*.—It should be made obligatory on employers to supply, free of charge, an adequate supply of cool drinking water in accordance with the rules framed and standards laid down by Provincial Governments.

(vii) *Bathing arrangements*.—Employers should provide, in the premises of industrial concerns, an adequate number of taps or showers for bathing after the operatives have finished their day's work. In certain cases it may be necessary to provide washing facilities and clean overalls before an operative begins his work, for instance, in establishments dealing with the preparation of food.

(viii) *Urinals and latrines*.—The number of urinals and latrines provided in industrial establishments, including plantations, should be in accordance with standards laid down either by statute or by health authorities. In places where municipal administration or a water borne system does not exist, employers should be made to adopt such methods of disposal of nightsoil as are recommended by the local health authorities with a view to ensure that its unsatisfactory disposal does not create a danger to the health of the community. We should again draw attention to our remarks in this connection under sub-paragraph (b) of para. 9 of our recommendations dealing with housing.

(ix) *Cloak room*.—We consider it desirable that, in every industrial establishment, employers should provide a place where workers should be able to keep their clean clothes in safe custody, before they enter the works premises in their working clothes.

(x) *Special clothing*.—Special clothing in all cases where the worker has to come in contact with obnoxious or injurious substances or substances likely to soil the clothing should be provided by the employers free of cost.

(xi) *Protective equipment*.—Gloves, goggles and such other protective equipment as may be necessary according to the industry in which the workers are employed should be provided by the employers free of cost and their use by the workers enforced.

(xii) Seats should be provided, wherever practicable, for workers at their work.

### **Rest Shelters**

(15) It should be made obligatory for every industrial establishment employing 100 persons to provide rest shelters and dining halls of approved types. Suitable furniture should also be provided in these shelters and dining halls. The standards for these, including furniture, should be laid down by rules framed by Provincial Governments. There should be separate provision for men and women. The walls and roofs of the rest shelters and dining halls should be made of non-conductive material, which would give adequate protection against heat, cold and rain.

### **Certification of Adolescent Workers**

(16) The requirements of the existing legislation regarding the employing of adolescents should be so modified as to qualify general practitioners approved by Provincial Governments to function as certifying surgeons. They will certify as to the general fitness of the adolescent for industrial employment.

When the industrial health service which we have recommended develops, it should be possible to provide for the examination of all workers with a view to placing them in departments in which they are best fitted to work.

### **Pre-employment Medical Examination of Adult Employees**

(17) As soon as the proposed occupational health service becomes fully developed all industrial establishments should institute a system of pre-employment medical examination of adult employees, including the clerical office staff. The examination should be of a thorough nature and the object to be aimed at should be to follow up the initial test by periodical examinations, at least once in three years. These examinations should be followed, where indicated, by suitable treatment and advice regarding the rectification of unhealthy modes of life.

### **Employment of Children in Industrial Establishments, Plantations etc.**

(18) (a) The minimum age for employment in industrial establishments, docks etc., should be raised to 15 and persons between 15 and 17 should be eligible for employment as adolescents on the certificate of the certifying surgeon.

(b) The minimum age for the employment of children on plantations and public works should be 13.

(c) In course of time when the compulsory school leaving age is raised and adequate educational facilities become available, employment of children under 15 should be abolished for all types of industrial establishments and occupations.

### **Inspectorates of Industrial Establishments**

(19) (a) The provincial factory inspectorates require strengthening and their status enhancing. The inspectorate should be sufficiently numerous to enable each industrial establishment in the Provinces to be inspected at least twice a year.



(b) The inspectorate should be divided into the following three divisions, each being staffed with persons possessing special technical qualifications :—

- (i) engineering, with special knowledge of safety laws;
- (ii) public health and
- (iii) social service or labour welfare work.

(c) The post of Chief Inspector is of sufficient importance and responsibility to attract men of high qualifications. He should be assisted by Regional Directors. The minimum general education for an inspector should be the intermediate in science of an Indian University or its equivalent. He should also possess some technical knowledge of factory practice and legislation and should undergo a short course in public health.

(d) The number of women factory inspectors should be substantially increased.

### **Unregulated Factories and Workshops**

(20) The need for regulating the conditions of employment in a number of establishments or trades to which the Factories Act does not apply or has not been applied, even when legal provision exists for such enforcement, is urgent. In our review of unregulated places of work earlier in this report, we have drawn attention to specific instances, which came to our notice during our tours, of establishments and trades in which the working conditions provided for the employees are, from the point of view of their health, of an extremely unsatisfactory nature. They include, among others, tanneries, *bidi* factories, the glass bangle industry and the building trade. Measures taken to regulate them should include the issue of a licence by a competent authority before the industry or trade can be started, the licence laying down specific conditions regarding the nature of the premises, ventilation, lighting, washing facilities, sanitary conveniences, hours of work and other matters which are necessary for ensuring comfort and protection against danger to health to all those who are employed.

There are obvious difficulties in the way of exercising efficient control over such establishments. Some are due to the fact that they are located in rural areas where supervision and control are not easy, and some to the fact that they are small, employ but few workers and are situated in congested areas from which they cannot readily be transferred. Many of these industries have existed for many years and fulfil a useful place in the economy of the country. Their workers have family traditions behind them and appear to be content with the conditions of their employment. The inspection of all these establishments will not be an easy matter for provincial governments, particularly as it should be so exercised as not to inflict undue harassment or hardship. At the same time we must point out that the working conditions in these establishments require radical improvement from the point of view of the health of the worker and of the locality, and that stricter inspection and control are essential.

We have already recommended that the occupational health service suggested in this chapter should, when fully developed, bring within its scope all forms of employment outside the home. When

this stage is reached all the occupations discussed in the preceding paragraph will have been brought under adequate control from the point of view of safeguarding the health of the workers. We would urge that a beginning should now be made to regulate and control the working conditions in the types of establishments described above. As has already been pointed out, it will be necessary to prescribe a minimum number of employees to bring such establishments within the law. This number will, no doubt, have to be determined by various considerations depending on local conditions and we must therefore leave the decision, in each case, to individual Provincial Governments. But we cannot urge too strongly the need for early investigation and appropriate action to bring such establishments under effective supervision.



## CHAPTER XI

### HEALTH SERVICES FOR CERTAIN IMPORTANT DISEASES

1. In this chapter we shall deal with the special measures we consider necessary in respect of the following diseases:—

- |                  |  |
|------------------|--|
| 1. Malaria.      | 7. Venereal diseases.                      |
| 2. Tuberculosis. | 8. Hookworm.                               |
| 3. Smallpox.     | 9. Filariasis.                             |
| 4. Cholera.      | 10. Guinea-worm.                           |
| 5. Plague.       | 11. Cancer.                                |
| 6. Leprosy.      | 12. Mental diseases and mental deficiency. |
|                  | 13. Diseases of the eye and blindness.     |

The majority of these diseases are communicable and we shall begin with a brief review of the existing provision, legal and administrative, for dealing with such diseases.

#### **A Brief Review of the Existing Provision, legal and administrative, for dealing with Communicable Diseases**

2. *Introduction.*—Herbert Spencer said long ago that perfect correspondence with environment would be perfect life. A healthy life depends on man's continuous adjustment to his environment. The vicissitudes of climate, his house, his workshop, the food he eats, the social life around him—all these form part of the environment which continually reacts on him and they determine, each in its own measure, his state of health or disease. This environment includes the many forms of life, animal and vegetable, that exist on the earth and, from time immemorial man and other living beings have been in conflict with one another in a continuous struggle for existence. From the point of view of undermining the state of his physical health and well-being a whole host of parasitic organisms, which gain entry into his body in various ways, have played an important role through the ages. While all forms of disease can be defined as departures from the harmonious functioning of the body owing to man's failure to adjust himself to the environment, the large group of illnesses resulting from parasitic invasion must be looked upon as a struggle for existence between man and the parasites which gain entry into his body. He fights the invader with all the powers with which he is endowed and, if he succeeds, he recovers from the disease and, in many forms of illness, the protective forces he has developed during the struggle continue to afford him sufficient strength to ward off an attack by the same organism for a long time afterwards. In other cases, the immunity conferred on him is of a transient nature. On the other hand, if the organism is able to overcome the resistance of the patient, the disease takes a grave turn and the man eventually dies. There is yet another outcome of the struggle on certain occasions. The man and the parasite establish a form of armed neutrality between themselves. The man outwardly re-establishes his health but the parasite has not been completely destroyed, as it has secured for itself a foothold somewhere in the man's body and continues to

live there. Thus is produced the carrier state as in the case of a small percentage of typhoid patients. When favourable conditions prevail the organism multiplies quickly and is excreted in the urine or faeces of the patient who, apart from the ill-effects on himself, thus becomes a potential source of infection to his fellowman.

## MEASURES FOR CONTROLLING COMMUNICABLE DISEASES

3. From this brief description of the genesis of disease it will be seen that the measures required for combating it fall into two broad groups, namely, (1) those which are concerned with an improvement of the environment in a wide sense of the term and (2) those which are specific for individual diseases. The former group includes the elimination of such factors promoting the spread of disease as the unhygienic home and its surroundings, overcrowding and unwholesome food and drink. As regards food, qualitative and quantitative deficiency can both be responsible for ill-health, as apart from specific types of infection which may be conveyed through its ingestion. The second group of measures consists of those which are necessary for promoting the development of special protection in the individual against particular diseases and for blocking the channels through which infection spreads, including unhygienic habits such as spitting. Control of the spread of infection is usually effected by such steps as the isolation and treatment of patients, who, in the majority of cases, become non-infective when cured, the enforcement of suitable measures against carriers, disinfection of infective material and the employment of adequate measures to eliminate, as far as possible, the vectors responsible for the transmission of individual diseases.

4. Broadly speaking, the law relating to the control of epidemic diseases is contained mainly in the different local Self-government Acts applicable to municipal and non-municipal areas in the provinces and in an all-India enactment, the Epidemic Diseases Act, 1897. The latter gives emergency powers to the different Governments, Central and Provincial, in their respective areas of administration, to promulgate temporary regulations to deal with an outbreak or a threatened outbreak of infectious disease. The Epidemic Diseases Act is meant to provide additional powers to health authorities over and above those which they possess under other legislative measures. Emergency regulations under the Epidemic Diseases Act have been generally issued by Provincial Governments during widespread outbreaks of epidemics or in connection with festivals which attract large numbers of pilgrims and are, therefore, associated with the threat of outbreak of these diseases.

5. The general administrative procedure in dealing with the control of infectious disease is briefly discussed below. As has already been pointed out, the matters discussed in the succeeding paragraphs may have been dealt with elsewhere in the report but, for the sake of convenience, they are again referred to here.

### Notification

6. The three epidemic diseases of cholera, small-pox and plague are notifiable throughout the country. The people are generally familiar with the manifestations of these diseases and, though no

completeness of notification can be claimed, it is safe to assume that the numbers recorded from year to year give a fairly correct picture of the extent and intensity of their prevalence. As regards the other diseases a varying number of these is compulsorily notifiable in different provinces. The numbers recorded can, however, be hardly considered as being indicative of the true extent of their prevalence. The number of diseases notifiable in municipalities is greater than in rural areas. In the former the Municipal Acts generally make the householder responsible for reporting cases of notifiable diseases to the health authority. Medical practitioners, including Vaidas and Hakims, are required to notify such cases as come to their knowledge during the discharge of their professional duties. In rural areas such provisions do not exist, the village officials being responsible for the reporting of cases of infectious disease.

7. The procedure for the transmission of information varies in the different provinces. For instance, in Bihar, when an epidemic breaks out, the village watchman (*chowkidar*) reports the matter to the officer in charge of the nearest police station, who in his turn reports to the Civil Surgeon, the Health Officer, the District Board Chairman and to the nearest dispensary doctor and Health Inspector. The Director of Public Health and the Assistant Director of Public Health receive the information from the Civil Surgeon. In this province, the village *chowkidar* attends the police station once a week. Therefore, the delay that takes place in the transmission of information regarding an outbreak of cholera, for instance, from the affected village to the nearest health inspector and dispensary doctor may extend perhaps to eight or nine days. On the other hand, in Madras the village headman, who is responsible for reporting epidemic diseases, sends simultaneously two copies of his report to the Tahsildar and to the Health Inspector of the area in order to enable the latter to start preventive measures as soon as possible. The Tahsildar sends daily a report to the Director of Public Health, the District Health Officer and certain other specified officers in the district. It will thus be seen that the period elapsing between the outbreak of an infectious disease and its notification to a responsible public health official varies among the provinces.

### **Preventive Measures**

8. (a) *Health staff*.—During the past quarter of a century rural and urban public health staffs have been appointed, in varying strengths, in the different provinces and the organisation of campaigns against the common infectious diseases has been one of the most important of their tasks. There has, however, been no striking change in the prevalence of these diseases. The reason is not far to seek. Even in those provinces in which the public health organisation has been best developed, *e.g.*, the provinces of Madras and the United Provinces, the strength of the staff available is quite inadequate for the large territories and populations entrusted to them. In the Province of Madras, for a district with an average area of 5,256 square miles and an average population of over two millions, the staff consists of one District Health Officer and, in addition, of one Assistant District Health Officer in most districts, with a Health Inspector in each taluk. The average area and population of a taluk are 540 square miles and 209,289 (1941 census) respectively. When it is remembered that the Health Inspector is required to perform a variety of health functions in the area, the inadequacy of the skeleton staff provided

even in a province where the best developed organisation exists, becomes apparent.

(b) *Inadequacy of existing legal and administrative provision for dealing with large scale epidemics.*—Public health administration is a function of local bodies, urban and rural. Statutorily, each is independent of the others and, for financial and various other reasons, the level of administration, including the carrying out of health functions, of local authorities is definitely low. Another noticeable fact is the general absence of legal sanction to enforce certain standards of performance by these authorities and to co-ordinate their efforts, which is of particular importance in the field of infectious disease control. The province of Madras is an exception. We have indicated in Chapter XVII that, in this province, the local health officers possess adequate powers to act promptly either in the presence of any notifiable disease or in anticipation of an outbreak of it, that the Director of Public Health has also been given sufficient powers to enable him to compel an unwilling local body to carry out such measures as he may deem necessary to meet the situation as well as to concentrate, in the area concerned, public health staff belonging both to the provincial service and to the services of other local bodies.

(c) *Protective vaccination against the common infectious diseases.*—Vaccination against smallpox has been practised in the country for over a hundred years and, although some reduction has been made in the incidence of the disease, its prevalence continues to be high. Many factors are responsible for this result and the question of smallpox vaccination will be discussed in greater detail in the section dealing with this disease.

Among other forms of vaccination, anti-cholera inoculation is the one protective measure which has been used extensively in the country. It has steadily gained in popularity during the past ten or fifteen years and is now generally accepted by the people without opposition. This subject will be discussed in greater detail in the section dealing with cholera.

(d) *Segregation of patients.*—The conditions existing in the vast majority of Indian homes, either in urban or in rural areas, are particularly favourable to the spread of infection and the need for the provision of facilities for segregation elsewhere, is therefore, great. It must, however, be remembered that, during times of epidemics, the number of patients requiring isolation, in respect of such diseases as cholera and smallpox, is considerable and well beyond the capacity of the local authorities concerned. In regard to tuberculosis and leprosy, the prolonged period of isolation that is required and the possibility of a relapse into the infective stage when the patient returns to active life necessitate, for the control of these diseases, much more elaborate measures than those required for the common epidemic diseases. In these circumstances, the practice of isolation in respect of any of these diseases is, broadly speaking, hardly prevalent in the country as a whole. Another disquieting feature of the situation is that, in the cities and larger towns, where infectious diseases hospitals are maintained, their condition from the point of view of buildings, staff and equipment is, generally speaking, very

unsatisfactory. During our tours in the provinces, the following infectious diseases hospitals were visited:—

*Madras—*

1. Infectious diseases hospital, Tondiarpet, Madras City.
2. Infectious diseases hospital, Ootacamund.
3. Infectious diseases hospital, Coimbatore.

*United Provinces—*

4. Infectious diseases hospital, Allahabad.
5. Infectious diseases hospital, Lucknow.
6. Infectious diseases hospital, Agra.

*Bengal—*

7. Infectious diseases section of the Campbell Hospital, Calcutta.

*Sind—*

8. Infectious diseases hospital, Karachi.

*Bihar—*

9. Infectious diseases hospital, Gaya.
10. Infectious diseases ward in the General Hospital, Patna.

*Orissa—*

11. Cholera Hospital, Puri.

The working of most of these hospitals is quite unsatisfactory. The buildings are not suitable, the staff is inadequate and the equipment is poor. Laboratory facilities are generally insufficient. In some cases, e.g., the United Provinces, the medical officer in charge is required to perform other duties as well, such as analysis of the local water-supply and anti-rabic treatment.

**Rectification of the above-mentioned defects**

9. *The areas in which our scheme will operate.*—We recognise that there can be no easy or rapid process of remedying effectively the defects outlined above. Our proposals for a comprehensive health service offering preventive and curative medical care to all, irrespective of their ability to pay for the service, constitute in our view the only solution to the problem. Even before such a service becomes established, our short-term proposals will help to start a promising attack on the control of the common epidemic and endemic diseases. If our recommendations in the chapter on vital statistics are carried out, a reasonable approach to completeness of registration is likely to be secured as well as a speeding up of the reporting of outbreaks of epidemics to the health authority. The primary unit staff, although small, should be able to carry out intensively such preventive measures as the sterilisation of water supplies and protective vaccination of the people against the disease concerned. Our proposals for protected water supply and for the satisfactory disposal of nightsoil in the areas under our scheme will help to decrease considerably the incidence of bowel diseases. An improvement of the environment, which is of great importance in the control of malaria, will be effected, it is believed, to a steadily growing extent through the voluntary effort that is expected to be stimulated in the villages by the proposed health committees. At the same time, the small trained group of 15 inferior servants in each primary unit will help to demonstrate to the villagers effective methods of carrying out minor antimalaria works, including the

spray killing of mosquitoes. It is in regard to the isolation of patients, where necessary, that the earlier stages of the programme will make the least provision. Any approach towards adequacy in this direction can be reached only with a large development of hospital accommodation. Even during the short-term programme a provision of 20 and 50 beds respectively has been suggested for the common infectious diseases in the secondary health centre hospitals of 200 and 500 beds recommended by us, while in respect of tuberculosis and leprosy, our proposals provide for an appreciable increase in existing hospital accommodation. It is in the countryside that facilities for isolation will be definitely slow. The small 30-bed hospitals, serving four primary units or a population of about 160,000, are likely to find themselves fully occupied with the treatment of general medical, surgical, obstetrical and gynaecological patients largely to the exclusion of those who suffer from such diseases as cholera, smallpox and plague. It is, however, to be hoped that the vigorous pursuit of the requisite preventive measures will reduce the actual incidence of these diseases to a considerable extent. The provision for isolation will become adequate only when the stage of the long-term programme, with its greatly expanded hospital service, is completed. We believe that even then home isolation will have to be practised to a large extent for a variety of ineffective conditions. We have recommended in the chapter on housing that the lowest type of house permitted to be built under the measures taken to control housing should have at least two living rooms in order to ensure the facilities necessary for isolating patients.

10. *The areas outside our scheme.*—It is not easy to put up any reasonably satisfactory proposals in regard to these areas. All the trained personnel that will become available through the implementation of our programme of professional education will, it is believed, be taken up during the first ten years and some years later.

11. The specific measures that are necessary for the control of these diseases may be considered separately. As regards notification, our proposals for the creation of a vital statistics organisation in the areas outside our scheme should help to secure a nearer approach to completeness of registration and avoidance of delay. Turning next to measures, curative and preventive, for dealing with outbreaks of such diseases we suggest that, as far as funds and trained personnel permit, provision should be made for the maintenance of two or three epidemic squads at the headquarters of each district in order that they may be rushed, without delay, to deal with such outbreaks. These squads would include medical men and staff to deal with the sterilisation of water supplies, disinfection of infective material and other preventive work. They should be provided with motor vans fitted up as travelling dispensaries with all appliances and other medical requirements for remedial and preventive work. These units can also play an important part in safeguarding the health of large aggregations of population on such occasions as festivals or fairs. In normal times they can be used to provide an itinerant medical service to areas which may be insufficiently served.

12. The widespread epidemics of such diseases as cholera and malaria which sometimes occur in various parts of the country can, however, hardly be controlled by the organisations outlined above. In our view, the Army with its well-manned and equipped health services should be utilised, where possible, to meet such emergencies.



Their usefulness during the Bengal famine and the wave of epidemics that followed it has been amply demonstrated. As far as we can see, there seems to be no reason for neglecting to use a part of the Army and its medical establishment, during times of widespread epidemics, to supplement the work of the civil organisation, particularly in areas where the latter is weak and unable to cope with the situation. Some of these major epidemics may constitute disasters of as great a magnitude as any war from the point of view of human suffering and mortality, and it would be unwise for the nation not to avail itself of all the means at its disposal for dealing successfully with such emergencies. The safety of the people should be our supreme consideration and no resources, Central or Provincial, should be left unused to ensure their protection and welfare.

18. We shall now put forward our recommendations for each of the diseases listed at the beginning of this chapter. In dealing with them the statistics that have been included relate generally to the period ending with 1941. The entry of Japan into the war in December of that year marked the stage at which conditions arising out of the war began to have marked adverse effect on India. In attempting to present a picture of the normal state of the public health in this country, against which our recommendations for health developments should be viewed, we have therefore considered it desirable to limit ourselves to the period ending with 1941.

## 1. MALARIA

### Introduction

1. Malaria is by far the most important disease in India from the point of view of sickness and mortality. Lieut.-Colonel J. A. Sinton, a malariologist of international reputation and a former Director of the Malaria Institute of India, has estimated that at least 100 million persons suffer from the disease every year in British India, that because of its effect in lowering the vitality of its victims it is also responsible for morbidity from other causes in an additional 25 to 75 million persons annually and that, directly and indirectly, it is responsible for at least two million deaths each year.

2. It is impossible to make any complete or accurate evaluation of all the losses for which malaria is responsible. For instance, it is difficult to assess the financial loss that the country suffers as the result of decreased productivity through the incidence of the disease. Col. Sinton has, however, estimated that, on an admittedly incomplete but conservative basis, the annual loss to the country, measured in terms of money, may be anywhere between Rs. 147 crores and 187 crores per year. If all the relevant factors could be taken into consideration, the loss is likely to be two or three times this estimate.

3. A tragic feature of the situation is that much of the malaria prevalent in the populated areas of the country is man-made. In many cases roads and railways have a sinister account to their credit. Their embankments often cause such interference with natural drainage as to create conditions favourable to the breeding of the malaria-carrying types of mosquitoes, while burrow-pits which follow the line of our roads and railways help to provide additional breeding grounds. Bengal is generally cited as an outstanding example of man's thoughtless interference with natural drainage resulting in the steady rise in the incidence of malaria over the greater part of that province. The failure of irrigation engineers to provide

for adequate drainage when water is brought into previously dry areas has been another fruitful cause of the spread of the disease. Recent examples of this are to be found in certain areas in Sind, the Province of Madras and Mysore. The first question with which we are faced is whether the great drain on the national health and prosperity caused by malaria is unavoidable. After the discovery by Sir Ronald Ross, towards the close of the last century, that certain types of mosquitoes are the transmitters of malaria, it has been demonstrated in limited areas in different parts of the world that the strict enforcement of anti-mosquito measures can effectively control the incidence of the disease. In the Panama Canal Zone, the first attempt to construct the Canal was frustrated by the ravages among the workmen of two mosquito-borne diseases, yellow fever and malaria. When, however, radical anti-mosquito measures were enforced in this area, these diseases were brought under complete control. The introduction of effective antimalaria measures at Ismailia in the Suez Canal area and in Algeria was attended by equally convincing results. In this country the Raipur-Vizagapatam section of the B. N. Railway could not have been constructed, had not malaria among the labour force been kept under control by an expert malariologist, while the Mettur dam and the Sarda Canal afford other instances where large irrigation projects were successfully completed with the help of malaria control measures.

In recent years even more effective preventive measures against malaria have become available, including potent chemicals for the destruction of the mosquito and drugs for protecting man against repeated infection. The remarkable manner in which the fighting forces of the Allies operating in highly malarious tracts have been protected against this scourge during the present war again bears testimony to the possibility of effectively controlling the disease. It is clear to us that, given the determination, the money and the requisite staff, it should be possible to reduce the incidence of the disease in India to small proportions.

### **Anti-malaria Measures**

4. The measures that are necessary against malaria fall under two main heads, namely, (1) those which are directed against the transmitter of infection, the mosquito, and (2) those which deal with man in his twofold capacity as a victim of the disease and as a reservoir of infection. Antimosquito measures may be grouped under the following heads:—

- (i) those which control the breeding of the mosquito and
- (ii) those which are directed against the insect in its adult form.

5. *Measures to control the breeding of mosquitoes.*—These measures take a wide variety of forms, although the main principles involved are the same, *viz.*, the obliteration of facilities for the laying of eggs by the female mosquito and the creation of conditions inimical to the survival of the insect in its larval stage in circumstances when egg-laying cannot be prevented. The steps that are necessary for these purposes include, among others, drainage to prevent accumulations of water, canalisation of water channels and the removal of vegetation from their sides, the use of larvicides such as mineral oils, paris

green and the more recent synthetic product D.D.T., selective clearing of jungle or shading of water courses in certain cases and the use of larvivorous fish.

6. There are many varieties of fish in this country which prey on mosquito larvæ. *Gambusia*, an American species of minnow, was introduced into India about twenty years ago and is being used in the wells in Bangalore and Bombay, the ornamental waters in Delhi and in many other parts of the country. This species has been proved to possess all the qualities required for antimosquito work and is probably more suitable for this purpose than any other species. It should be emphasised however that the value of fish is very limited. They are useful in artificial collections of water like ornamental waters but their use is of doubtful value as a general anti-larval measure.

7. For dealing with the malarial conditions created by large constructional works and irrigation projects, well-planned schemes requiring considerable technical supervision and heavy expenditure will be necessary. These can obviously be undertaken and carried out only by the State. On the other hand, in many parts of the rural areas, effective results may be secured by works of a minor nature, such as the filling up of pools and ditches so as to prevent collections of water or other measures already mentioned such as oiling, removal of vegetation, etc. In our short-term programme, we have made certain suggestions for the carrying out of such measures in rural areas. We have provided for a small labour force of 15 in each primary unit, one of whose duties will be to see to the carrying out of these minor works. These men may be unable to deal effectively with the whole area covered by such a unit, but an important part of their work, will lie in their being able, as a trained group, to demonstrate to the villagers how to go about these tasks properly. We hope that the village committees we have recommended (*vide* Chapter IV) will be able to mobilise voluntary local effort in carrying out such measures and that we shall thus be able to enlist a tremendous force in the fight against this disease. The small labour squad will also form the nucleus round which, during an epidemic, an expanded organisation can be rapidly built up.

8. It is desirable that the planning and execution of these anti-malarial works should, as far as possible, receive technical guidance and we have recommended the appointment of an Assistant Public Health Engineer at the headquarters of each secondary unit for this purpose. Direct local supervision will be provided by the medical officer in charge of the primary unit and his two public health inspectors.

9. Although we hope that the local effort we have referred to will help to reduce the cost of labour, sufficient public funds should be made available to ensure that the required expenditure will be fully met. We have included in our budget for each primary unit a provision for meeting this expenditure.

10. *Measures against the adult mosquito.*—The Director, Malaria Institute of India, has pointed out that the results of spray-killing operations carried out in various parts of the country hold out the hope that “we have at last a weapon which, when its full possibilities have been developed, will prove effective for rural, as well as urban and industrial, malaria”. Pyrethrin, the active principle extracted

from the flower of the pyrethrum plant, has been found to be an effective insecticide and has been used extensively as a spray for the killing of adult mosquitoes. The synthetic product, D.D.T., has provided an even more effective insecticide than pyrethrum. The great advantage of D.D.T. over pyrethrum is its residual effect, while pyrethrum is superior to D.D.T. in its immediate knock-down effect. A combination of the two products has been tried on a relatively small scale and found to give satisfactory results. The purpose of this measure is to kill *infected* mosquitoes and to reduce the longevity of mosquitoes in an area, so that the number which live long enough to become malaria carriers is reduced to the minimum. This measure has been developed during the last few years and is of special value where anti-larval measures may take too long to give results, or as a supplement to such measures.

These operations against the adult mosquito will be undertaken in the rural areas by the squads of 15 labourers that have been provided in each primary unit with, we hope, the active support and assistance of the villagers.

We shall deal with the subject of ensuring adequate supplies of these insecticides for the use of the health departments in India later in this chapter.

### Measures in relation to Man

#### (a) *Man as a victim of the disease—*

11. *Treatment.*—Here the primary need is to ensure adequate treatment. This involves a proper diagnosis where possible and a sufficient supply of the requisite drugs. While it may not be practicable to have a microscope at every primary health centre, it should be possible to send blood-smears for examination, when necessary, to the nearest 30-bed hospital and obtain a diagnosis without undue delay. During times of epidemics, however, the primary need will be for the immediate distribution of antimalarial drugs.

12. Quinine has for long been the drug of choice in the treatment of malaria. More recently, atebirin (or mepacrine as it is now being called) has also come widely into use. After an extended study of the comparative values of quinine and atebirin for the treatment of the disease, the Malaria Commission of the League of Nations came to the conclusion in their fourth report (1937) that, while atebirin was more effective against certain species of the parasite, quinine was more potent against others. In India, under the conditions arising out of the War, many millions of tablets of mepacrine have been widely distributed among the general population for the mass treatment of malaria in view of a shortage in the supply of quinine. So far no untoward results have been definitely substantiated from this widespread use of the drug, though careful investigation in regard to the matter will no doubt have to be continued. Further, experience of the distribution of this drug to Allied fighting forces in the Tropics under conditions, which preclude any degree of control over its use by the individual, has also led to the conclusion that it can be used with safety for mass treatment. Recent investigations suggest that an even more effective synthetic product, paludrine is likely to come into use at an early date. In these circumstances, there is the possibility that synthetic products may, in due course, come to replace, to an appreciable extent, the use of quinine as the routine drug for the treatment of malaria.

13. *Other measures.*—The use of quinine and mepacrine as suppressive agents for preventing the development of malaria has been extensively tried among troops continuously exposed to infection in highly malarious areas. The consensus of opinion appears to be that quinine has but small value as a suppressive agent, the reason probably being that it is excreted quickly and does not, therefore, remain in sufficient concentration in the circulation. Mepacrine has, on the other hand, a much slower rate of excretion and has been found to be more effective than quinine when used for this purpose.

The question of production of adequate quantities of quinine and of mepacrine for the needs of the country will be discussed later.

14. Equally important is the question of affording protection to a healthy person against the bite of an infected mosquito. The measures that are generally adopted include, in addition to the killing of adult mosquitoes, the use of mosquito repellents on exposed parts of the body and of mosquito nets and mosquito coils with pyrethrum as the base as well as the screening of houses so as to prevent the entry of the insect. These are all undoubtedly useful but, as measures for the general population in malarious places, they seem to be of limited practical application.

15. (b) *Man as a reservoir of infection.*—The life of the parasite is passed partly in man and partly in the mosquito. In man it exists in two forms, namely, one which undergoes the asexual type of reproduction during which the malarial attack is produced and the other, the male and female sexual elements, which, on ingestion by the mosquito, unite and by further development in that insect, give it the power of infecting man. Plasmoquine has been found to be effective in killing these sexual forms when they circulate in man's blood. In these circumstances, a course of plasmoquine treatment, following medication for curing an attack, should be advocated as tending to reduce the chance of infection being conveyed to mosquitoes.

#### **Anti-malaria Organisations at the Centre and in the Provinces**

16. In an article entitled "The public health aspect of malaria control" in the Indian Medical Gazette of December 1942, Major-General G. Covell, I.M.S., Director, Malaria Institute of India, made the following observations:—

"An essential preliminary to the successful control of malaria in India is the formation of an adequately staffed *permanent* malaria organisation in each province, the activities of which should be linked up with those of the central organisation of the Government of India."

17. We fully endorse this view. One of the great defects of the anti-malaria campaign in India during the past 50 years was that it consisted of a series of spasmodic attempts to control the disease. This lack of continuity of effort, accompanied as it often was, by the employment of an organisation with insufficient staff and equipment, has been largely responsible for the inadequacy of the results achieved. As we have already said, it has been amply demonstrated, during the present War, that, with adequate measures, even the highly malarious regions of the Tropics can be rendered comparatively safe from this disease. Again we have pointed out, in our review of existing conditions, how the malaria organisation, which

has been working in the Delhi urban area for the past seven or eight years, has shown that, under civil conditions also, a reasonably effective control of the incidence of the disease can be achieved provided adequate funds are expended under the best available technical advice. In these circumstances, we feel that there can be no excuse for Governments in this country not attempting to organise an effective campaign against the disease. Its wide prevalence, the cost involved and the existing inadequacy of trained personnel may result in this campaign being extended over perhaps many years. Even so, it is most important that a beginning should be made and, in the following paragraphs, specific proposals are made towards this end.

18. *Central Malaria Organisation.*—The Malaria Institute of India is the central organisation for advising the Government of India on all matters relating to this disease as well as for assisting Provincial Governments with such technical advice as they may require. Its functions have been defined by the Director of Malaria Institute in the following terms:—

“1. To be fully informed upon all malaria problems. To advise Government on all issues relative to malaria in India.

“2. To initiate enquiries and investigations on malaria. To carry out such inquiries as Government may for any reason require. To assist provincial organisations in the carrying out of such inquiries as may be undertaken by them, providing such assistance as desired and even, in certain cases when thought necessary, to lend officers temporarily from the staff to work under local government.

“3. To undertake systematic research in due course into all the basic facts underlying malaria transmission, prevalence and prevention, such as the study of mosquitoes, systematic and bionomical, types of malaria parasites, transmission power of different species of Anopheles, mechanism of infection including the study of endemic and epidemic phenomena, etc. Gradually to complete and organise knowledge on these subjects and to arrange for the making of such knowledge available for practical application, or such other uses as may be desirable.

“4. To carry out epidemiological investigations—mapping of endemicity, study of hyperendemic and healthy areas, study of malaria statistics on modern lines—and generally to elucidate the underlying principles of malaria prevalence in India.

“5. To advise upon and assist in the carrying-out of antimalaria measures. To study these scientifically and to judge and elucidate their results.

“6. To undertake clinical work on malaria, including treatment. To study serum reactions and allied aids to diagnosis and understanding the disease. To study relapse problems, effects of new drugs, etc.

“7. To assist affiliated researches (e.g., kalaazar, filariasis, sandfly fever, dengue, *Stegomyia* work) by identification of material, provision of trained staff and subordinate personnel.

“8. To teach and train officers and others in practical malaria work.

“9. To publish scientific results, useful guides, bulletins, etc.

"10. To keep alive interest in malaria study and prevention and to see that such interest wherever present is nursed and assisted."

We are in full agreement with the Director that these should be the main functions of the Malaria Institute of India.

The permanent establishment of the Institute consists of a Director, an Assistant Director, an Entomologist, an Assistant to the Director, a Malaria Assistant and appropriate subordinate staff. The new posts of a Deputy Director, an Assistant Director and of certain subordinate staff, which were recently created as a temporary measure for the duration of the war, should be made permanent. In view of the large developments that are likely to take place in the activities of this malaria organisation the Central Health Department should bear in mind the importance of ensuring that it is adequately staffed.

19. *The provincial malaria organisation.*—The general plan should be the creation of an organisation at the headquarters of each province and, in addition, a number of malaria control units to operate in malarious areas in the districts. The number of these units will obviously depend upon the size of the province and the extent and degree of the prevalence of malaria in it. As an illustration, we may set out a plan for the province of Bengal. We think that about 150 such units will eventually be required for that province, but a beginning may be made with ten. Others can be added as and when additional trained staff and funds become available. But it is essential that, even from the beginning, suitable transport should be provided for these control units in order to increase their mobility and effectiveness.

In the larger provinces it will be necessary to provide regional organisations also in order to ensure that adequate supervision is exercised over the peripheral malaria control units. In the smaller provinces, however, such regional organisations may not be necessary. Here the Provincial Malaria Officers and their staff should be able to carry out, the necessary supervision. This Provincial Officer should have the status of an Assistant Director of Health Services, and the Regional Malaria Officers may be designated Deputy Malaria Officers.

The complete organisation for a large province such as Bengal, may be developed on the following lines:—

1. Provincial Headquarters—

Provincial Malaria Officer . . . . .	1
Entomologist . . . . .	1
Sanitary Engineer . . . . .	1
Overseers . . . . .	4
Draftsman . . . . .	1
Antimalaria Officer . . . . .	1
Antimalaria Assistants . . . . .	2
Laboratory Assistants . . . . .	5
Insect Collectors . . . . .	8

2. Deputy Malaria Officers . . . . . 5

3. Malaria Control Units—

Antimalaria Assistant . . . . .	1
Laboratory Assistants . . . . .	2
Malaria Supervisors . . . . .	5
Fitter Mistri . . . . .	1
Field Workers . . . . .	25

Antimalarial fieldworkers are semi-skilled labourers and should not be considered as coolies.

Lists of suitable equipment for the malaria organisation at the provincial headquarters and for the malaria control units are given in Appendix 14 of Volume III of the report.

These estimates of the malaria organisation desirable for a province such as Bengal, including staff and equipment, were prepared for us by the Director of the Malaria Institute of India. He has suggested the following approximate number of malaria control units for the different provinces.

	No. of control units		No. of control units
Madras . . . . .	100	N. W. F. Province . . . . .	30
Bombay . . . . .	60	Sind . . . . .	60
Bengal . . . . .	150	Ajmer-Merwara . . . . .	5
United Provinces . . . . .	150	Baluchistan . . . . .	30
Punjab . . . . .	60	Delhi Province . . . . .	2
Bihar . . . . .	100	Coorg . . . . .	5
Orissa . . . . .	50		
Central Provinces and Berar . . . . .	100		982
Assam . . . . .	80		

He has stated that, in calculating these requirements, he took into account such factors, in respect of each province, as the area, population, number of districts, number of villages and the degree of prevalence of malaria as indicated by (a) statistics of malaria mortality and (b) the percentage of fever cases on total cases treated at hospitals and dispensaries.

20. In our view, the most essential requirements are adequately trained personnel in sufficient numbers and the drugs, appliances and other equipment for carrying on effectively the campaign against the disease. We would, as a general rule, deprecate the spending of large sums on the erection of elaborate buildings in the early stages of our programme for, we believe that such money as is likely to be available can, at the beginning, be much more effectively used on staff and antimalarial measures.

21. We once again feel it necessary to stress the incalculable value of good rural communications in increasing the effectiveness of all health and other workers employed on nation building tasks in such areas.

22. For details regarding the staff required for such an organisation reference may be made to Appendix 14. The total expenditure involved in the development of malaria organisations in the Provinces and at the Centre, on the lines suggested by us, during the first five and the second five years of our short-term programme will be as under:—

	Non-recurring Expenditure	Recurring expenditure
	lakhs	crores
First five years . . . . .	9.17	2.52
Second five years . . . . .	11.10	3.85

These estimates have been made on the assumption that, during the first five years of the programme, the average number of malaria



control units which will be established in individual Governors' Provinces will be 10 and that, during the next five years, fifteen more such units will be added in each province. For each of the Centrally Administered Areas the corresponding number of units proposed is five for each quinquennium.

#### **Provision for the Hospitalisation of Malaria Patients**

23. When our short-term programme for the first ten years has been completed, provision for hospital accommodation for all classes of patients for the country, as a whole, should consist of (1) 30-bed hospitals for every group of two primary units, (2) 216 hospitals with 200 beds each and (3) 139 hospitals with a bed strength of 500 each in addition to the existing hospitals. While in the small 30-bed hospitals it will be difficult to allocate special beds for malaria, we have recommended the reservation of 10 and 25 beds respectively for this disease in the 200 and 500-bed hospitals. Thus the number of beds available for the treatment of malaria will be, at the end of the ten year period, a little over 5,600.

24. By the time our long-term programme is reached such provision for malaria should have increased to the extent shown below:—

Primary unit hospitals	Secondary unit hospitals	District headquarter hospitals	Total
112,500	6,250	2,500	121,250

The number of primary units, by the time this stage is reached, is likely to be in the neighbourhood of 18,500 to 19,000. Each primary unit hospital will provide six beds for this disease, and in view of the wide distribution of these units, provision for hospitalising such patients will be spread throughout the country. In addition 10 and 20 beds, respectively, have been provided for malaria patients in the hospitals located at the headquarters of secondary units, which will generally correspond to the headquarters of a sub-division, and at the district headquarters respectively.

We trust, however, that before this stage is reached, effective and persistent anti-malarial measures will have resulted in materially reducing the need for hospital treatment for sufferers from malaria.

#### **The Training of Malaria Personnel**

25. It is anticipated that a certain proportion of the trained personnel of the anti-malaria organisation at present employed in the Army will become available for the development of the civil malaria establishments in the provinces after demobilisation. Nevertheless, in the immediate post-war period it will be necessary to train a large number of medical officers in order to fill such posts as those of the Provincial and Deputy Malaria Officers, Officers in charge of control units, Entomologists and Malaria Engineers. We recommend that the training of these types of personnel should, in the immediate post-war period, be carried out in the Malaria Institute of India. It seems to us essential that the development of anti-malaria activities in the provinces should be promoted on fairly uniform lines and that the training of these higher types of malaria personnel should, therefore, be carried out at the Malaria Institute of India for some time to come.

26. On the other hand, the training of overseers, technicians and inspectors or supervisors can be carried out by the Provincial Malaria

Organisations in those provinces which have well-developed malaria establishments, namely, Bombay, Madras, the United Provinces, Bengal and Assam. Until the remaining provinces develop similar organisations the requirements of the Punjab, the N. W. F. Province and Sind can be met by making provision for the training, every year, of a certain number of these types of personnel at the Malaria Institute of India, Delhi. Other provinces can perhaps secure similar facilities by negotiation with the neighbouring provinces where the training of such malaria workers will be developed to meet their own requirements.

27. It will be seen that the training facilities to be provided at the main Institute at Delhi will thus be considerable. These training functions will necessitate the strengthening of the staff of the Institute beyond the additions suggested by us earlier in this chapter. We recommend that the Central Health Department should take immediate steps to investigate and determine what further strengthening of the establishment will be necessary in order to provide the training facilities the post-war health programme will require.

We think that the officers of the anti-malaria organisation in the provinces should be able to train locally types of workers such as laboratory assistants and attendants, insect collectors, etc.

28. We wish to make it clear that these recommendations of ours for concentrating the training of the higher types of malaria personnel at Delhi are of a purely temporary nature. When the anti-malaria organisations in the provinces become fully developed the provision of training facilities for all types of malaria workers should, in our view, be the responsibility of Provincial Governments. We have suggested, later in this chapter, the creation of Chairs of Malariology in selected medical colleges in order to provide facilities for undergraduate and postgraduate training in the subject as well as for stimulating research. Thus the provinces should, in due course, develop facilities for the highest type of training that may be required in Malariology.

### **Quinine and other Drugs for the treatment of Malaria**

29. We have already referred to the use of quinine and mepacrine for the treatment of malaria. It is possible that other drugs of greater therapeutic value may also be discovered as the result of scientific research. It is, therefore, not easy to estimate accurately what levels of production in India should be recommended for the immediate future in respect of quinine and mepacrine, in order to ensure that proper treatment facilities are made available to a substantial proportion of the sufferers from malaria. All of us are, however, agreed that it should be the responsibility of Governments, Central and Provincial, to take, in mutual consultation, such steps as are necessary to ensure the production in India of antimalaria drugs in sufficient quantities to meet the requirements of the country within the shortest possible period. We are equally agreed that the country should not again be placed at the mercy of a private monopoly which can control, to its own advantage, the price of these drugs which are essential for the maintenance of the health of the people. Whether, in making adequate provision for these drugs, Governments should themselves undertake extensive programmes of production or whether private enterprise can be relied on to supply

the needs of the country through any system of guarantees or subsidies from the State, are matters on which we are unable to express an opinion with the information at our disposal. We can only lay down three general propositions:—

1. the prices at which anti-malaria drugs are made available to the people should be sufficiently low to enable the poorest classes to obtain them in adequate amounts for the effective treatment of the disease;
2. these drugs, in whatever provinces they may be produced, should be made available, on an equitable basis and on reasonable terms, for the needs of all parts of the country and
3. no delay should be allowed to occur in developing their production.

We shall first consider the production of quinine.

30. (a) *Quinine*.—If Colonel Sinton's estimate that at least one hundred million individuals suffer from the disease every year be taken as the basis of calculation, it does not seem unreasonable to assume that there will be at least 120 to 150 million cases to be treated annually in view of the fact that more than one attack is not an uncommon feature of the disease. The Malaria Commission has recommended 75 grains of quinine as the minimum quantity necessary for the treatment of a case. On this basis the amount of quinine required will be in the neighbourhood of 1.3 to 1.6 million pounds per year. If quinine is to be relied upon as the sole drug for the treatment of malaria our objective should be an annual production of it to the extent of about 1.5 million pounds from cinchona bark produced in the country. Some of us hold the view that this should be the definite objective which Governments should place before themselves and that every endeavour should be made to attain it within the shortest period that may be practicable. Others feel that the experience gained during the War with the large scale use of mepacrine in the treatment and prevention of malaria in highly endemic areas, makes it necessary to take into account the possibility of this drug replacing quinine to a greater or less extent in the treatment of the disease and that it would, in the circumstances, be safer to start with a more limited objective in regard to the production of quinine. The average annual consumption of quinine in India in the pre-war period was 210,000 lbs. and, of this amount, about a third was produced in India, a part of such production being, we believe, from bark imported from Java. As a practical objective for realisation as early as possible those of us who hold this view recommend the raising of quinine production to the pre-war level of consumption in India, namely, about 210,000 lbs. from indigenous bark alone. A cinchona plant begins to yield bark generally from the fifth year of its life, the period of high productivity being from the fifth to the ninth year. After the twelfth year its yield gradually decreases. In these circumstances the raising of the annual production of quinine even to the 210,000 lbs. mark from bark produced in the country will take some years. In the meantime the possibility of synthetic drugs displacing quinine, wholly or in part, in the treatment of malaria may well be settled. This is a question of considerable importance which should be decided before

embarking on too ambitious a programme of quinine production. Such a programme is certain to involve heavy financial commitments which would not be justified if it became possible to produce cheaper and equally effective synthetic substitutes.

31. We, as a committee, would prefer to leave to the Governments in the country the responsibility for deciding whether private enterprise should or should not be associated with the production of quinine and of other anti-malaria drugs. If it is decided that such association is desirable it would be for Governments to determine the conditions under which private agencies should participate in production. One of us (Sir Frederick James), however, desires to see that private agencies are given the fullest opportunity to take part in quinine production with technical advice and a price guarantee provided by the State. We attach our colleague's note on the subject. We fully support his suggestion that research into the agricultural and manufacturing aspects of the quinine industry should be a governmental responsibility and that two experimental stations should be established to serve North and South India respectively.

32. (b) *Mepacrine*.—The pre-war annual consumption figure of 210,000 lbs. of quinine will provide treatment, at the rate of 75 grains per patient, for about 19.6 or nearly 20 million cases of malaria. If, as an immediate objective, we accept the provision of adequate anti-malaria drugs for the treatment of 50 million cases annually, then sufficient mepacrine will have to be produced to meet the requirements of 30 million patients. The minimum quantity of this drug for a complete course for a patient is 1.5 grammes or 15 tablets of 0.1 gramme each. The manufacture of 450 million tablets of mepacrine a year in India should, therefore, be the immediate objective.

33. *Pyrethrum and D. D. T.*—The main sources of pyrethrum, before the War, were Kenya and Japan but the cultivation of the plant has been successfully undertaken in various parts of India, including Kashmir, the Punjab Hills, the U. P., Central Provinces, Madras and Orissa. It has been shown that the yield of the active principle from the plants, grown in many parts of India, compares favourably with the flowers obtained from Kenya. In these circumstances, it may be reasonably expected that, in the course of some years, there will be an ample supply of pyrethrum grown in this country to meet all local demands. The Director, Malaria Institute of India has estimated that, in order to make the country self-sufficient, pyrethrum cultivation will have to be extended to about 120,000 acres so as to produce annually about 15,000 short tons (2,000 lbs. a ton) of pyrethrum flowers. This estimate makes allowance for a sixth of the total area under cultivation lying fallow each year.

34. As an insecticide the relationship of D. D. T. to pyrethrum is somewhat similar to that of mepacrine to quinine in the treatment of malaria. There is the possibility, in both cases, of the synthetic substance replacing, to a greater or less extent, the use of the other. It may, however, be pointed out that the indiscriminate use of D. D. T. has been shown to result in the destruction of certain types of beneficial insects. It is quite likely that, in due course, adequate safeguards will be discovered and introduced in order to prevent

these detrimental effects. There is also the possibility that insecticides more potent than D. D. T. may be produced and brought into use. While recognising that these possibilities should be given due weight, we think that the cultivation of pyrethrum in India should be developed until the use of D. D. T. has become established. Even when this stage is reached, the production of a certain amount of pyrethrum will still be necessary, if as has been suggested a combination of D. D. T. and pyrethrum is more effective than either of them alone. Another reason which has prompted us to advocate the continuance of its cultivation is that at short notice, it can, if necessary, be given up and replaced by other crops. Here again the steps required to foster the increased growth of pyrethrum must be decided by Governments after a full examination of the relevant factors.

We can only stress the necessity for a largely increased supply of pyrethrum flowers at a reasonable price and the duty of Governments in India to take immediate steps to ensure production on a scale sufficient for the needs of the country.

35. *Clinical research in malaria.*—While one line of attack on the malaria problem is through the control of the carrier types of mosquitoes, another should be directed towards the elimination of the reservoirs of infection. As relapses are quite common in malaria, a person who suffers from an attack of the disease continues, in an appreciable percentage of cases, to harbour the parasite for a varying length of time. The complete destruction of all the parasites in such persons should form an important part of an anti-malarial campaign. One of the limitations of all anti-malarial drugs so far available (including quinine, mepacrine and plasmoquine) is that they help to kill only such of the parasites as are present in the circulating blood of the patient while those which are harboured in the spleen and other internal organs escape. The achievements of chemotherapy have, during recent years, been so brilliant that it is quite conceivable that a drug may be discovered with power to kill the parasite not only in the circulating blood but also in those internal organs in which it finds refuge. Any such drug when discovered and tested in the laboratory can be considered to be effective only by a reasonably large field trial on human beings. We feel that there is need for the active promotion of combined biochemical and clinical research aiming at the evolution of a suitable drug which will help not only to cure the patient for the time being, but also to destroy the parasites in him completely.

36. We consider the promotion of active research in malaria to be of fundamental importance in this country. The creation of Chairs of Malariology in selected medical colleges is a highly desirable step in this connection. These professorships would serve a double purpose, namely, the fostering of research in malaria and the provision of adequate facilities for undergraduate and postgraduate training in the subject.

37. *Legislation.*—The effective enforcement of anti-mosquito measures requires suitable legislation and we have given, as appendices 15, 16 and 17 respectively, the Model Mosquito Ordinance of the United States Public Health Service, the Straits Settlements Destruction of Mosquitoes Ordinance No. 174 and those sections of the Bombay City Municipal Act which deal with anti-mosquito measures, in order that they may be examined by the different health

authorities in the country with a view to seeing how far they may be followed as models.

**Certain Suggestions by Sir Frederick James, O.B.E., M.L.A., for increasing Quinine Production**

38. (1) Before deciding on the method of increasing the production of cinchona bark in India it would be well to study the production methods in the Netherlands East Indies which, before the War, supplied over 90 per cent. of the world's quinine. Their dominating position has been achieved through a combination of Government and private efforts and the systematic way in which the industry has been organised.

(2) Nine-tenths of the cinchona produced in the N. E. Indies comes from private plantations, but the improved types of cinchona and the improved methods of cultivation and propagation are derived from the work carried out at the Government cinchona plantations. Judged by ordinary standards of commercial accountancy the production of cinchona on private estates will always be cheaper than on Government estates. If, therefore, the aim is to produce quinine at as reasonable a cost as possible, every attempt should be made to persuade planters to take up its cultivation.

(3) A Central Cinchona Bureau for India similar to the Kina Bureau of the Netherland East Indies should be established. Such a Bureau might well have two experimental stations, one situated in the North and the other situated in the South with plantations attached. If such a Bureau were placed under the Imperial Council of Agricultural Research, and private planters were associated with it, India would have taken the first step towards raising cheap cinchona, for the only bark which is really cheap is the bark of the high yielding types.

(4) The main work on both these experimental stations would be the study of plant breeding, vegetative propagation, cultivation, manuring and the regeneration of plantations, which had already finished one cycle of cinchona growing.

(5) One of the reasons why cinchona production has been so backward in India is its provincialization in Madras and Bengal, the lack of an all-India policy, and the failure of the Governments concerned either to associate experienced planters with the development of their stations or to encourage private enterprise.

(6) On page 153 there are two general propositions:—

(a) 'That the prices at which anti-malaria drugs, including quinine, are made available to the people should be sufficiently low to enable the poorest classes to obtain them in adequate amounts for the effective treatment of the disease'. This will involve a certain amount of price control and, in the event of private plantations being encouraged, profit control also. But the planting of cinchona is a risky enterprise and if profits are to be controlled in order to ensure that the price of quinine is kept at a reasonably low level, then a guaranteed offtake at a fixed price is the only inducement which will encourage private enterprise. The world price of cinchona has fluctuated around Rs. 20 per lb. and the experience of the Netherland East Indies has shown that a reasonably profitable industry can be a sound basis for a normal and constant production. This should be recognised by those who wish to see quinine provided at a cheap

price, for it can only be achieved if economy is effected in the costs of production and distribution by efficient management, or funds are provided from public revenues to meet the loss incurred by inefficient production. Costs of production can be reduced by scientific research and efficient organisation, and of this, industry is well aware.

(b) That no delay should be allowed to occur in starting new plantations on an adequate scale. If a Central Cinchona Bureau is established, it should be fairly simple to plan production with a view both to ensuring supplies of bark to existing factories and where new areas are being opened up for the maintenance of other factories in full production.

Government stations should also assist by raising plants of good quality for sale to private growers. Sales would be partly adjusted to the cinchona which they desired to establish in any areas.

The cinchona industry should be essentially an all-India concern, but at present it is provincial and dealt with by two provincial Governments. If the price guarantee is agreed to by the Central Government, then it could be made conditional on a certain amount of control over policy, both of extensions and scientific research. If the Madras and the Bengal Governments are not prepared to associate the Imperial Council of Agricultural Research with the planning of the work at their stations, then the Central Government should establish its own research station in Coorg which is a centrally administered area and is suitable for plantation of cinchona.

## 2. TUBERCULOSIS

### Introduction

1. Dr. P. V. Benjamin, Medical Superintendent, Union Mission Tuberculosis Sanatorium, Arogyavaram, South India, has estimated that the average annual number of deaths from tuberculosis in India is in the neighbourhood of 500,000 and that about 2.5 million open cases of tuberculosis exist in the country. These patients are continually disseminating infection among those with whom they come in contact. If these estimates can be accepted as reasonably correct, they provide some measure of the magnitude of the problem that faces the country.

2. While no surveys of sufficient magnitude have yet been undertaken to map out the distribution and intensity of tuberculosis infection in the country as a whole, the information available suggests that, broadly speaking, the incidence of the disease is higher in urban and industrialised areas than in rural regions. There is also reason to believe that, owing to the migration of labour population between industrial and rural areas and the increased facilities for road and rail transport that have been developing during the past, the tendency has been for tuberculosis to spread to the countryside. Certain social customs, such as purdah and early marriage, which often promotes a rapid succession of confinements, are favourable to the spread of the disease while such factors as malnutrition and under-nutrition, insanitary and overcrowded housing conditions, also contribute their share to the dissemination of infection.

3. Existing facilities for an effective campaign against the disease are altogether meagre. With about 2.5 million infective tuberculosis patients in the country the total number of beds available for

isolation and treatment is in the neighbourhood of 6,000. The number of doctors with sufficient experience of tuberculosis work to qualify them for posts in tuberculosis institutions does not probably exceed 70 or 80, while those who have had a short course of four weeks in the subject may number about 250 or 300. Fully trained tuberculosis health visitors are in all probability only about 100. These figures help to indicate the immensity of the task that has to be accomplished before satisfactory control can be established over the disease.

4. The attack on the disease should be launched simultaneously in two directions, namely, (1) towards an improvement of the socio-economic condition so as to provide for the people a higher standard of living, including better housing, adequate nutrition and sanitation of the environment in and around their homes, their workplaces and places of public resort, and (2) towards an effective control of the spread of infection from patients to those who are healthy. The importance of measures to improve living condition has been amply demonstrated in other countries where, even before anti-tuberculosis measures were instituted, the mortality from the disease began to fall as the result of a rise in the general standard of living. While such measures are no doubt important, a direct attack on the reservoirs of infection is equally necessary. Without it any marked fall in the incidence of the disease cannot be expected. The amelioration of social conditions, including an improvement of housing and a raising of the standard of nutrition, goes beyond our field of enquiry, although we have referred, in appropriate places, to the necessity for sustained State action towards the achievement of definite results in these directions. We shall, therefore, devote ourselves here to the question of controlling the incidence of the disease through measures directed towards restricting the spread of infection.

#### **Control of the Spread of Tuberculosis Infection**

5. The measures which we consider necessary are briefly indicated below:—

(1) Isolation of infective patients and the provision of adequate treatment for them in order to make them non-infective.

(2) In the homes of such patients some of their co-residents may also be suffering from the disease without their being recognised as patients. Tuberculosis often starts in an insidious way and many patients have been known to go on working until a serious breakdown in health takes place. Therefore, the contacts of all infective patients require examination and, if there be continued exposure to infection, there should be provision for their periodical examination.

(3) Patients, who become non-infective by treatment may, if they return to normal life and its strenuous duties, suffer a relapse and become infective again. The provision of a more sheltered life with facilities for employment suited to their state of health, under adequate medical supervision, constitutes a further important step in the organisation of anti-tuberculosis measures. In this connection, the establishment of after-care colonies in association with every large tuberculosis hospital is a proposal which we shall consider later in this chapter.



(4) A certain proportion of the patients is generally so advanced as to make recovery practically impossible in spite of the best medical attention. For such patients what is required is that the final release from pain and suffering should be made easy to the utmost possible extent and homes for incurables should form a part of the anti-tuberculosis organisation.

(5) A comprehensive scheme of anti-tuberculosis activity cannot be carried out without the provision of adequate numbers of trained health personnel of the different categories that are necessary. Therefore certain proposals for the short-term programme in connection with the provision of the required training facilities and the creation of a tuberculosis service will be referred to briefly here.

6. The measures under (1) and (2) above may be considered together. Isolation and treatment of infective patients are best carried out in tuberculosis hospitals and sanatoria. In the more advanced countries the provision for tuberculosis beds varies between the rates of one and three beds per tuberculosis death in the community. On these ratios India will require somewhere between half to 1.5 million tuberculosis beds, if Dr. Benjamin's estimate of 500,000 annual deaths from this disease is to be made the basis of calculation, while, as has already been pointed out, existing provision is in the neighbourhood of 6,000 for the country as a whole. While promoting the establishment and maintenance of tuberculosis hospitals as far as possible, it is clear that our approach to the solution of the problems of isolation and treatment will have to be on a much broader basis. The number of open cases requiring isolation will be in the neighbourhood of 2.5 to 3 millions. Presumably, it will be impossible to expand hospital accommodation, within any reasonable length of time, to provide for all these patients. The most satisfactory method, therefore, of providing for the segregation of a reasonable proportion of the infective patients seems to be through the simultaneous development of a scheme for the isolation and treatment of patients in their own homes on as large a scale as possible. We, therefore, place an organised domiciliary service in the forefront of our tuberculosis programme. We recognise that, under existing conditions, there are numerous difficulties in the way of establishing such a service. We shall discuss these later when we deal with organised home treatment in greater detail.

#### **A Comprehensive Tuberculosis Service**

7. In order to provide a comprehensive and integrated service the tuberculosis organisation should include (1) a domiciliary service (2) clinics (3) hospitals (4) aftercare colonies (5) homes for incurables and, in addition, (6) certain ancillary welfare services.

8. *A home isolation and treatment service.*—In the vast majority of cases the spread of the disease is by an open case infecting, through coughing and spitting, persons who are in relatively close contact. Children and young adults are particularly liable to infection. Certain simple precautions, if conscientiously carried out by the patient, will suffice to make him comparatively harmless to those with whom he lives. He must live in a separate room, have his own towels, crockery and other articles for personal use, protect his mouth with a handkerchief or a piece of cloth soaked in a suitable disinfectant when he coughs, spit into a small bottle or paper spittoon containing the disinfectant and, in general, observe the rule that

neither by coughing nor by spitting does he spread infection to others. The paper spittoon may be burnt with its contents while the cloth or the bottle may be sterilised by boiling. Such simple precautions should go a long way towards controlling the spread of infection. In these circumstances, if suitable accommodation is available in the patient's house for his isolation, the question of treating him there with proper safeguards against the spread of infection should present no serious difficulty. The existence of adequate facilities for isolation is important and this matter will be discussed presently.

9. We have already referred to a scheme for organised home treatment in Delhi in our review of tuberculosis in volume I of this report. The limited success which has been attained is due to (1) certain difficulties arising out of the war (2) the extremely unsatisfactory housing of the poorer sections of the community and (3) the inadequacy of the funds made available for the scheme.

10. The question of housing seems to present the greatest difficulty in respect of tuberculosis patients of the poorer classes who live in single room tenements where isolation is impossible. It seems essential, as has been pointed out in the chapter on housing, that post-war plans for improved housing for the people should take into consideration the fact that, in a country like India where a high incidence of morbidity from communicable diseases exists, domiciliary service must play an important part in the provision of adequate health care. Apart from tuberculosis many infective conditions, particularly those affecting children, will have to be treated in the majority of cases in the home and the provision of a room where suitable isolation can be practised seems, therefore, to be essential. We recommend that, as a part of the anti-tuberculosis campaign, local health authorities should make themselves responsible for the construction and maintenance of a number of suitable dwellings into which the patient and members of his family can be removed. As has already been pointed out, the problem is most acute among the dwellers of one-room tenements. They will, on removal, have to be provided with accommodation free of charge. It must be remembered that housing implies certain social amenities such as contact with neighbours and friends and, when families are required to move away from their existing tenements, they are hardly likely to accept the offer unless free quarters are offered to them.

11. *The Tuberculosis Clinic.*—This institution is an essential link in the chain of organisations for the campaign against tuberculosis. It performs preventive and curative functions of great importance. The treatment facilities it offers will help to cure a certain number of patients while the more advanced cases will be sent for treatment in hospital. The clinic is the centre on which the domiciliary treatment service for tuberculosis will be based. On the preventive side, the public health nurses working in association with the clinic will participate in the organised home treatment programme, advise patients on the carrying out of effective isolation, persuade their contacts to attend the clinic for examination and early detection of the disease, if present, and, in general, help to promote the welfare of patients and their families by establishing contact between them and voluntary organisations interested in welfare work. On the curative side, such of the patients as can undertake periodical visits to the clinic without aggravating their condition will receive medical attention at the clinic. Those, whose condition is too advanced for

attendance at the clinic, will receive domiciliary treatment from its medical staff. The nurse will be present on such occasions and, in the intervals between visits by the doctor, will carry out such measures as may be prescribed by him.

Thus the clinic will form the centre from which both curative and preventive work in tuberculosis will spread into the homes of the people.

12. *Tuberculosis hospitals.*—The more advanced cases, which the clinic cannot deal with adequately, as well as those patients for whom isolation at home is not possible should find admission into tuberculosis hospitals. In view of the difficulty of finding accommodation for even an insignificant fraction of those requiring institutional treatment, it is suggested that only such patients as are likely to benefit thereby should be admitted into hospitals. For the incurables we suggest separate provision later.

As has already been pointed out, the provision of sufficient hospital accommodation to meet the requirements of the country is bound to take many years and, in the meantime, the organisation of a domiciliary treatment service, with such facilities as can be made available, appears to offer a practical line of advance in the control of the disease.

13. *After-care of patients.*—In a considerable proportion of cases, tuberculosis patients do not completely recover their previous health and, after they return from the hospital to the adverse home and working environments, which were responsible for the onset of the disease, relapse may take place. It is, therefore, essential that less strenuous working conditions and a more hygienic home environment should be provided for him. In such circumstances, the patient can continue to work and earn something towards his maintenance. Apart from this economic benefit, employment enables him to take his mind off his physical condition as well as to develop a sense of self-respect and remove the feeling that he is helpless and at the mercy of others. The physical exertion associated with his employment, provided it is regulated by proper medical supervision, is calculated to have a beneficial effect on his health. To meet these requirements we recommend that after-care colonies should be established in close association with every tuberculosis hospital that will be developed under our scheme.

14. *Homes for incurables.*—As has already been pointed out, the need here is for the provision of such care as will make the final phase of sickness reasonably comfortable for the patients. The homes that we suggest for such persons need not be built, equipped and maintained on a scale suitable for hospitals. There must, however, be provision for some measure of medical and nursing care. We recommend that Governments should undertake the responsibility for building and equipping such institutions. Their maintenance can, it is believed, be suitably entrusted to philanthropic or religious organisations interested in social welfare. Governments undertaking to meet a substantial part of the expenditure through generous grants.

#### **Provision during Long and Short-term Programmes**

15. We shall now indicate briefly the provision, we have recommended in our short and long-term programmes, for anti-tuberculosis work, including the creation of training facilities for doctors and other personnel.

*Institutional service—*

The first five-year period :

- (1) The establishment of a 200-bed tuberculosis hospital for each unit of 10 million population;
- (2) The establishment of a large clinic (to be designated the "Main Clinic"), with facilities for the training of medical and non-medical tuberculosis personnel, at each of the places where the 200-bed hospital will be created.

On the assumption that the population of British India will be about 330 millions by the time the first five years of the programme will be completed, the number of hospitals and main clinics required will be 33 each.

- (3) The establishment of clinics of a smaller type at the headquarters of each district in British India. The total number required, after deducting the 33 main clinics, will be 183.

Second five-year period :

- (1) 33 more 200-bed hospitals;
- (2) 33 more main clinics at the same places where the new hospitals will be located and
- (3) 183 more district clinics.

The clinics and hospitals can serve only limited areas around the places where they are located. Even so, in these limited areas a domiciliary tuberculosis service should be organised in association with each clinic. A certain number of suitable cases will be sent by the clinic to the nearest tuberculosis hospital for more satisfactory treatment than can be provided locally.

We have not indicated where and in what numbers homes for incurables should be established. We have only thrown out the suggestion and would leave the matter for suitable action by the health authorities concerned.

While these proposals of ours are undoubtedly an advance on the existing state of affairs and will bring some measure of relief to limited sections of the population, the need exists for extending, as far as possible, such aid to the vast population of the rural areas also. The problem is by no means easy of solution. We may, however, put forward certain suggestions for consideration.

16. *Travelling tuberculosis units.*—The tuberculosis organisation outlined above provides for peripheral units only at the headquarters of districts. One way of extending the activity of this organisation is by providing travelling tuberculosis units based on the district clinics and working as far into the rural areas as possible. These units will be motor vehicles so equipped with all the necessary drugs and appliances, including provision for X-ray examination of patients, as to enable them to carry diagnostic and treatment facilities of a reasonably high order to the areas served by them. The medical officer in charge should have had special training in the subject and should be assisted by suitable subordinate staff.

17. In our health development scheme, we have recommended the establishment of a 30-bed hospital for groups of four primary units and of a dispensary at the headquarters of each primary unit. The medical officers in charge of these institutions will, while carrying

out medical relief, come across numerous frank and suspicious cases of tuberculosis. In order to help them in the diagnosis and treatment of such patients the travelling unit should, as a routine measure, visit these institutions at stated intervals. The two medical officers in charge of the primary unit and the four public health nurses will, apart from the medical relief given at the dispensary, carry curative and preventive care, as far as it lies in their power, into the homes of the people. In doing so, they will come across and deal with a certain number of tuberculosis patients. With the help of the ambulances that are available cases requiring the specialised skill of the doctor in charge of the travelling unit can be brought to the primary unit headquarters for examination and suitable advice. The examination of suspected cases among the contacts of such patients can also be undertaken by the unit. Thus the special facilities necessary for dealing with the disease can be extended into the rural areas also even during the short-term programme.

18. We anticipate that the need for a sufficient number of workers with special training in tuberculosis will probably postpone the inauguration of the travelling unit system to the beginning of the second five year term. We are advised that, if these travelling units are to give adequate service, they should be able to pay at least three or four visits per month to the headquarters of each primary unit and the places where the 30-bed hospitals are located. By the end of the first five years the number of primary units included in a secondary unit is likely to be 10 and, during each of the succeeding five years there is likely to be an addition of three primary units. At the end of the first 10 years of our programme the number of primary units in each district will probably be 25. The proposed minimum of at least three visits by a travelling tuberculosis unit to each place in a month will necessitate about 35 to 40 such visits a month during the sixth year of the programme and about 70 to 80 visits during the 10th year if the whole area under our scheme in each district is to be properly served. Such travelling units required for each district will probably be two in the sixth year and four in the tenth year, on the assumption that, with the time taken for journeys and for work at the institutions to be served, the number of visits will probably be about 20 per month. Inadequacy of trained personnel and insufficiency of funds will, in all probability, make it difficult to provide, during the short-term programme, the number of travelling units indicated above. We would suggest that provision be made, in each district, for one such unit during the sixth and seventh years of the programme and for two during the next three years. We consider it essential that the service given to the people should be adequate and satisfactory, and we would therefore suggest a restriction of the area over which these travelling units will operate rather than an expansion of their activities over the whole territory covered by the scheme. The operation of this itinerant service can be extended as and when funds and trained personnel become available.

19. Another direction in which the travelling unit can help materially in the tuberculosis campaign is by carrying out intensive educational propaganda in the areas visited. A sufficient amount of educational material, including films, magic lanterns and slides, leaflets and posters should be carried by the travelling unit and every effort should be made to interest the people, including the local medical profession, in the subject of tuberculosis.

20. We consider it essential that, in our tuberculosis programme, such funds as are available should be devoted to the expansion of staff and equipment and not to the erection of costly buildings. In large parts of the country the weather is mild throughout the year and massive buildings for providing protection against extremes of cold and heat are unnecessary. Moreover, the tuberculosis patient feels all the better for as much fresh air and light as can be given, provided he is adequately protected against the direct rays of the sun and rain. Considerable saving in expenditure on buildings can, therefore, be effected and all available money should be devoted to the provision of adequate health services and of such ancillary aids to recovery as good food, suitable clothing and other comforts for poor patients.

21. *The Long-term programme.*—The following figures indicate the extent to which provision for the treatment of tuberculosis will be made by the time the long-term programme is completed.

*Number of beds for the treatment of tuberculosis*

Primary unit hospitals	Secondary unit hospitals	District headquarters hospitals	Total
75,000	75,000	67,500	217,500

There will be about 18,500 or 19,000 primary units scattered all over the country. The provision for tuberculosis in the hospitals located in these units will make treatment facilities widely available among the people. The total number of beds available for the isolation of infective patients will be about 217,500 or a little less than the ratio of 0.5 bed to each of the 500,000 estimated deaths from tuberculosis. As has already been pointed out, in the more progressive countries existing provision ranges from 1 to 3 beds per tuberculosis death. It is to be hoped that, by the time the long-term programme is completed, the cumulative effect of all the health measures we have recommended will be to reduce substantially the mortality from this disease.

### Training Facilities

22. We have dealt with the subject of training in tuberculosis for doctors and public health nurses in the section dealing with professional education. A reference to this matter is also made here in order to indicate briefly the provision for training which is to be made during the short-term programme.

23. The number of places, where facilities can be developed within a short time for the training of tuberculosis workers, medical and non-medical, is at present limited to five in British India. It is proposed that these should be supplemented by seven more training centres to be developed in the provinces during the first five years of the programme. During the next five years each of the 200-bed hospitals and each of the main clinics in association with it should form a training centre. Thus there will be 45 centres working throughout the second quinquennium. It is also anticipated that, of the 88 new areas where a 200-bed hospital and a main clinic will be established, about 20 may be able to function as training centres during the last two years of the period.

24. We are advised by a special Sub-committee of tuberculosis experts, which we appointed, that about 13,000 medical men will require special training in tuberculosis in order to meet the requirements of the country. As regards public health nurses, we have

already stated our view that the same nurse should, when visiting the homes of the people, carry out all the functions relating to tuberculosis, maternity and child welfare, school health and other branches of health activity. It will thus be seen that the number of nurses to be trained in tuberculosis work will be considerable. A rapid expansion of training facilities has been suggested in order to meet this need for large numbers of trained doctors and nurses.

### **Tuberculosis Surveys**

25. In order to provide a sound basis for the organisation of an effective campaign against the disease, information regarding the extent and nature of its incidence is essential. Information should be available as to which communities are most affected and what particulars age groups and which of the two sexes require special attention. A tuberculosis survey is meant to provide data throwing light on these problems. Such a survey may also reveal special factors, such as social customs and habits, economic and environmental conditions, which may have a bearing on the incidence of the disease and whose elimination or control should form an essential part of the anti-tuberculosis campaign in the group or community concerned. Tuberculosis surveys should thus constitute a necessary function of the organisation for combating the disease.

26. We have already pointed out in our survey of tuberculosis in Volume I that, in any community in which the disease has been prevalent for some time, appreciable sections of the population take up the infection, often in the early years of their life. In the vast majority of such persons the defensive mechanism that the human body possesses is able to deal with the infection effectively. Adverse socio-economic and certain other factors, such as the period of exposure to infection, the size of its dose and the age of the person largely determine whether the power of the invading organism to do harm becomes neutralised by the resistance of the individual or whether the organism gains the upper hand and is able to produce the disease. Even where the infection is suppressed for the time being it may lie latent and the individual may, some years later, develop tuberculosis under the stress and strain of hard living conditions. Thus, in a community in which tuberculosis has been prevalent for many years, persons who are healthy may, after some time, develop the disease either as the result of a recent infection or of a more remote one, which had been lying latent. A well-conducted tuberculosis survey will provide information regarding the extent of prevalence of infection in the community as well as the number of early and more advanced cases. In the more advanced countries of Europe and America, repeated surveys of the same population group are now being attempted as a valuable aid in detecting early cases, which are more amenable to treatment than patients in an advanced stage of the disease.

27. In our short-term programme, with the limited resources at our disposal and with the need for providing remedial and preventive care as widely as possible, we feel that large-scale surveys will not be possible. Nevertheless, the domiciliary health service, which we have recommended for development in association with every clinic, will itself constitute, in its day-to-day functioning, a survey of a somewhat limited character. At the same time, it is desirable that the trained staff of the clinic should undertake, as far as possible, surveys in limited population groups such as industrial workers. Such

surveys should include the determination of the rate of infection in the community concerned as judged by skin tests such as the Mantoux test and mass miniature radiography, as well as the detection of cases in all stages of the disease. Information regarding environmental and other factors associated with the incidence of tuberculosis should also be collected. In order to ensure that such surveys are carried out satisfactorily we cannot do better than suggest the adoption, by health authorities, of the recommendations contained in a memorandum embodying detailed instructions for the conduct of tuberculosis surveys, which was prepared by a special sub-committee appointed by the Tuberculosis Association of India.

### **Welfare Services**

28. Welfare services form an essential part of the anti-tuberculosis organisation. If a patient, who is a wage-earner on whom his family is dependent, is to be removed by the health authority as an open case and, therefore, dangerous to the community from the point of view of the spread of infection, it is necessary that his family should receive adequate financial help to maintain themselves. The field for welfare work is extensive and includes such matters as the provision of adequate nourishment, clothing, better housing and other comforts to necessitous patients and their contacts as a part of the domiciliary treatment service. Similar provision to after-care colonies should also be a function of the welfare organisation.

### **The place of Voluntary Organisations in the Anti-Tuberculosis Campaign**

29. We have already referred, in the review, to two major organisations engaged in the campaign against the disease, namely, the Tuberculosis Association of India and the Bengal Tuberculosis Association. The former has its branches in all the provinces and in a number of States while the activities of the latter are confined to Bengal. While realising fully that, whatever extensions of State activity in the field of health may develop in the future, there will always remain, as far as we can see, opportunities for voluntary effort to play its part, we think that a demarcation of their respective spheres of action is desirable. In our view, it should be the responsibility of Government to make adequate provision for the care of all tuberculosis patients who are infective. The ultimate objective should be to ensure that no open case is left unprovided for. As regards after-care and welfare services we believe that Governments cannot absolve themselves of their responsibility, but voluntary agencies can also find here a field which offers a wide variety of useful activity in the interests of the community. The Tuberculosis Association of India has, during the few years of its existence, performed such functions as the offering of technical advice, through its Medical Commissioner, to Provincial and State health authorities, the organisation of special training courses in tuberculosis for doctors and health visitors, the holding of All-India conferences of tuberculosis workers and educational propaganda. The division of functions between Government and voluntary bodies, which has been suggested above, will make it the duty of Governments to train the required types of workers in adequate numbers and to maintain properly equipped and staffed anti-tuberculosis services. The duties that are now performed by the Medical Commissioner of the Tuberculosis Association of India should, in our view, be carried out by an expert staff which should be maintained on the establishment of



the Director-General of Health Services with the proposed Central Ministry of Health. All-India conferences should also be arranged under the same auspices. In these circumstances, voluntary effort will tend to operate largely in the spheres of welfare service and educational propaganda. Such activities should, we suggest, receive from Governments financial and technical assistance where this may be required.

### 3. SMALLPOX

#### Introduction

1. The average annual number of deaths from smallpox in British India, excluding Burma, during 1902-1941 are given below:—

Period	Average annual mortality
1902-1906 . . . . .	84,914
1907-1911 . . . . .	94,534
1912-1916 . . . . .	79,214
1917-1921 . . . . .	84,828
1922-1926 . . . . .	66,075
1927-1931 . . . . .	77,902
1932-1936 . . . . .	83,959
1937-1941 . . . . .	54,989

Although averaging in quinquennial groups of years has introduced a certain amount of smoothing, it will be seen that the above figures present a considerable degree of variation from one five-year period to another. This is due to the fact that the epidemic prevalence of the disease differs to a great extent from year to year. Even after taking into account this fact, it is considered that the disease has shown some decrease during recent years. The average annual number of deaths from smallpox in British India during the period of ten years, 1932-41, was 77.4 per cent. of the corresponding figure for a similar period of ten years at the beginning of the century, 1902-11. When allowance is made for the increase in population that has taken place since the beginning of the century, the average rates of mortality from smallpox per 100,000 of the population are seen to be 40 and 25 respectively in the two ten-year periods under consideration. A decline in the incidence of the disease, as judged by mortality figures, is therefore evident. There is no room, however, for complacency when it is remembered that the average number of deaths per year from this disease during 1932-41 was as high as 69,484. Further, the annual epidemiological reports published by the League of Nations show that India has the highest rate of incidence of smallpox among the countries for which statistics are given.

2. Another disquieting feature of the situation is that, of the total mortality from smallpox, appreciable proportions are recorded at the age periods 0-1 and 1-10. During the five-year period, 1937-41, deaths due to smallpox among infants under one, when expressed as percentages of the total mortality from this cause at all ages, ranged from 12.1 to 19.7 and, during the same period, the corresponding percentages for children between one and ten years varied from 19.2 to 30.5. In order to show how heavy the incidence of the disease has been on these two age groups, we give below certain figures which are quoted from the 1937 Annual Report of the Public Health Commissioner with the Government of India. The expected

figures shown in the table have been calculated on the assumption that persons of both sexes and of all ages are equally liable to smallpox. It will be seen that, in practically every province, the actuals are in excess of the expected figures. The selective incidence of the disease in these two age groups is, therefore, clear.

*Deaths from Smallpox*

	1937			
	Under one year		Between one and ten year	
	Actual	Expected	Actual	Expected
North-West Frontier Province . . . . .	248	30	609	262
The Punjab . . . . .	1,480	149	1,821	1,017
Delhi . . . . .	244	20	359	142
United Provinces . . . . .	933	99	1,034	785
Bihar . . . . .	458	182	798	1,981
Orissa . . . . .	267	61	391	505
Bengal . . . . .	2,414	928	7,452	7,161
Central Provinces . . . . .	170	16	224	114
Bombay . . . . .	410	55	804	447
Sind . . . . .	128	22	401	204
Madras . . . . .	677	68	713	599
Assam . . . . .	227	67	333	289

3. Apart from the extent of suffering and loss of human lives which these figures represent, it must be remembered that the complications that often accompany an attack of smallpox may produce, even when the patient survives, various forms of disability, one of the most important being blindness. The high incidence of the disease among infants and children naturally results in such disabilities being produced in individuals who have to pass the greater part of their lifetime with such handicaps as these disabilities will entail.

### **Vaccination against Smallpox**

4. This abnormally high incidence of suffering, incapacitation and death is all the more deplorable because smallpox is perhaps the most easily controllable among the infectious diseases. If vaccinations are performed at regular intervals with a potent vaccine lymph the level of immunity in the population can be raised so high as to eliminate smallpox as a community disease. The introduction of the infection on different occasions may give rise to sporadic cases but an outbreak of smallpox on a scale likely to threaten the public health will be rendered impossible.

5. The success that can be achieved in eliminating smallpox through vaccination has been demonstrated by the history of the

disease in the Philippine Islands. For many years smallpox caused more than 44,000 deaths annually in that country. After the introduction of systematic vaccinations the disease almost disappeared. Thus in six provinces, where smallpox used to be responsible for an average annual mortality of 6,000 deaths due to this cause became reduced to an insignificant figure. In Manila, with a population of over 250,000, not a single death from smallpox occurred during a period of seven years. On the other hand, when the vaccination of new-born children and fresh arrivals in the city was not effectively carried out between 1915 and 1919 the disease reappeared and over 700 deaths were reported as the result of the epidemic. To quote an instance from India, we may turn to the Province of Madras. In 1922 and 1923, the Provincial Government introduced, in each district, a health organisation consisting of a District Health Officer and a Health Inspector for each taluk. The employment of this staff gave an impetus to the campaign of vaccination against smallpox and increasingly larger numbers of primary vaccinations and revaccinations were done each year. In 1932, compulsory revaccination for the whole population was introduced in municipal and non-municipal areas throughout the province, except Madras city. The maximum interval prescribed by law between successive vaccinations is 10 years. In the city of Madras, compulsion was introduced in 1936 and the prescribed interval is seven years. The substantial increase in the percentage of protected persons in the population resulting from these measures is reflected in the steady fall in the mortality from smallpox which is shown by the figures quoted below:—

*Average annual death rate per mille from smallpox in the province of Madras*

Period	All ages	Above the age of 10
1917-21 . . . . .	0.77	3604
1922-26 . . . . .	0.46	1747
1927-31 . . . . .	0.17	0751
1932-36 . . . . .	0.22	0362
1937-40 . . . . .	0.06	0392

The large fall in smallpox mortality, at all ages, in the period, 1937-40, as compared with the corresponding rate for those over ten years of age suggests that the vaccination campaign must have been more effective in protecting children under ten with their normal rate of high incidence of smallpox than older persons.

### OUR PROPOSALS

6. The measures that are necessary for combating the disease are, (1) the isolation and treatment of patients, (2) observation of contacts during the period of incubation of the disease and their isolation as soon as they develop fever, in view of their becoming infective at this stage and (3) the enforcement of vaccination among the people at periodical intervals in order to raise their immunity to the highest possible level. In regard to the measures indicated under (1) and (2) above, it must be remembered that smallpox is highly infectious and that a patient becomes infective from the early stages of the onset of the disease. Therefore, it is almost certain that the patient will have passed on the infection to those who live with him sometime before the health authority becomes cognisant

of the occurrence of the disease. Further, in the presence of an epidemic, the provision of facilities for isolating all cases is well beyond the resources of most local authorities in the country. The range of infectivity of the disease is so great that home isolation affords little protection to the other members of the family. Under such conditions, observation of contacts has little meaning as a preventive measure. In the circumstances and particularly in the beginning of our health programme, intensive vaccination of the population at regular intervals appears to afford the quickest and the most effective means of controlling the disease. We shall, therefore, deal with this subject in some detail in the succeeding paragraphs.

7. We may set out our recommendations separately for (1) the areas that will be included in our health development scheme during the short-term programme and (2) those outside the scheme. Before doing so, we may discuss certain points which are common to both. These have already been referred to in our survey of smallpox in volume I of this report, but are again being briefly presented here for the sake of convenience.

### 8 Existing Position

#### (a) *Compulsory vaccination*—

(i) *Primary vaccination*.—Primary vaccination is not compulsory throughout the country. In 1941, only about 81 per cent. of the towns and 62 per cent. of the rural circles in British India were enforcing primary vaccination. There is no reason to believe that any appreciable increase has taken place since that date in the number of areas in which primary vaccination is enforceable. In the provinces, the percentage of towns enforcing compulsory primary vaccination varied from 100 per cent. to 52.7 per cent. The provinces backward in this respect are the N.-W. F. Province, the United Provinces, Bombay and Assam. In the Province of Bombay, primary vaccination was enforceable only in 4.9 per cent. of the rural circles while in the N.-W. F. Province, the United Provinces, Sind, Assam, Coorg and Ajmer-Merwara, primary vaccination was not compulsory even in a single rural circle.

(ii) *Revaccination*.—There is no specific provision in the vaccination Acts of the provinces for compulsory revaccination. In the province of Madras revaccination is, however, compulsory under the provisions of the Local Self-government Acts relating to municipalities and non-municipal areas. In these Acts, the appropriate section states that vaccination shall be performed "as prescribed". Taking advantage of this provision, the Provincial Government issued statutory rules making revaccination compulsory throughout the province. In other provinces, the information available from the Annual Reports of the Public Health Commissioner shows that, occasionally, revaccination is made compulsory for limited periods and in specified areas through Temporary Emergency Regulations which are issued under the Epidemic Diseases Act.

(b) *Training of vaccinators, their recruitment and conditions of service*.—There is considerable variation in the provinces as regards the training given to vaccinators, the methods of their recruitment and their conditions of service. The duration of the training varies from three to ten months. The salary paid to vaccinators ranges from a minimum of Rs. 10 per month in Bengal to a maximum of

Rs. 50 to a first class vaccinator in Madras. In the provinces of Bihar and Orissa the conditions of service for vaccinators are most unsatisfactory. In Bihar paid vaccinators are employed only in municipalities and the scales of pay which are sanctioned by individual municipalities naturally vary. In all cases they are extremely low. In the rural areas vaccinators are given no salary at all nor do they receive any travelling allowance. The fees they may realise from the people for vaccinations carried out in their homes are their sole remuneration. They are engaged for work only for the vaccination season (October to March) but may be called upon for further duty during emergencies.

(c) *The methods of production of vaccine lymph at the different vaccine institutes.*—Vaccine lymph production is undertaken at the provincial centres of Belgaum, Lahore, Patwa Dangar, Calcutta, Guindy, Nagpur and Ranchi. The lines of production at the Institutes in all these places follow generally the accepted procedure in other countries. There is therefore no need for any marked departure from existing practice.

(d) *The conditions, under which vaccine lymph is distributed and used by vaccinators.*—There is reason to believe, from certain investigations carried out by an Officer on Special Duty in the office of the Public Health Commissioner with the Government of India, that the present methods of distribution of vaccine lymph are not such as to ensure its potency when actually used.

(e) *The vaccination season.*—In the provinces vaccination is carried out only during the cold weather, usually from October to March, the underlying idea being that in the hot weather the greater exposure to heat of the vaccine lymph is likely to produce a deterioration in its quality. The result is that for about half the year no vaccination is carried out unless there is an outbreak of smallpox.

### **The Rectification of the above-mentioned Defects**

9. We consider it essential that primary vaccination should be made compulsory throughout the country without delay. The Province of Madras has shown that periodical revaccination can also be introduced and worked successfully even in the rural areas. In our view other Provincial Governments should follow this example as early as possible.

10. Vaccination against smallpox should be the normal function of a properly developed health service such as we have recommended and no special class of vaccinator should be employed. In the early stages of our health programme their employment will, however, continue to be necessary in the areas outside our scheme. So long as this is so every endeavour should be made to remove the existing wide disparity between the provinces in regard to their training and conditions of service. The period of training should be about six months. Apart from the technique of vaccination, they should be taught (1) to keep their records correctly, (2) to check the unprotected children's register in the villages during their tours as well as the birth and death registers, on the accuracy of which the correctness of the unprotected children's register will depend and (3) to carry out such duties as sterilisation of wells and the reporting of cases of infectious disease which come to their notice during their tours.

11. As the health organisation, we propose, will not be functioning in these areas it is desirable that the services of the vaccinator should be utilised not only to protect the people against smallpox but also to carry out various minor duties which will help to raise health administration to a higher level than that which prevails at present.

12. No man can be expected to do public health service satisfactorily unless he is adequately paid for it. We recommend a scale of pay of Rs. 40—2—70 for a vaccinator and security of tenure. We have suggested this scale of salary because we consider that, as our health scheme expands, the more efficient among these vaccinators should, after such additional training as may be necessary in each case, have opportunities of being promoted as health assistants and later as public health inspectors. The scales of pay which we have recommended for the two latter posts are Rs. 60—5—100 and Rs. 100—5—150.

13. The question of ensuring the potency of vaccine lymph during its use in the field and of extending the vaccination season into the hot weather are inter-connected. We recommend that the possibility of providing facilities for cold storage in a number of places in each province, in order to keep the lymph at its original strength for prolonged periods, should be investigated. The development of a number of such centres in a province will help to shorten the period of exposure to heat that the lymph has to undergo during its use in the field. With the creation of such storage facilities it should be possible to carry out vaccination throughout the year.

### **OUR RECOMMENDATIONS**

#### **The Areas under our Scheme**

14. Vaccination against smallpox should be one of the normal functions of the public health inspectors, public health nurses and midwives employed in each primary unit. We realise that the establishment of a special class of vaccinator was justified in those days when this was the first form of public health activity taken up by the authorities. But vaccination is only one of the many forms of specific protection against particular diseases which the Health Department should provide for the people and the operation itself is so simple that there is no justification for the employment of a special staff for this purpose in the areas where our health programme will be introduced.

15. The average population of a primary unit in our short-term programme is about 40,000. The aim should be to ensure adequate protection to the whole of this population. In view of the unsatisfactory results which have so far been achieved by vaccination in the past, particularly in the rural areas, we recommend that during the first year the whole population should be vaccinated. Thereafter, the operation need be repeated only every five years. In Java it is understood that one man can vaccinate 500 persons per day provided proper arrangements are made for the collection of the people beforehand. Even assuming that this standard of efficiency may not be attained immediately in India, 250 persons per day cannot be considered as an unreasonably high figure. The total work involved in a primary unit is, therefore, about 160 man days and, when distributed among a staff of 10 persons

including the public health inspectors, nurses and midwives, it represents for each individual only 16 days' work in the year. Taking into consideration failures of vaccination and the need for repeating the operation the total period for each member of the staff should not extend beyond 18 or 20 days.

### **The Areas outside our Scheme**

16. An intensive campaign against smallpox should be organised without delay in these areas also. With the type of training and improved conditions of service we have already recommended for the vaccinator we believe that a reasonably efficient worker will be produced, who will help to raise not only the level of immunity against smallpox in the population, but also to make more effective the campaign against other diseases such as cholera, through the preventive work he would perform.

17. The average number of vaccinations performed in a year by a vaccinator differs considerably in the provinces. It was as low as 1520 in Bihar in 1939 while the highest figure of 7,587 was recorded in the Punjab as against an average of 2,951 for British India as a whole. Among the eleven Governors' Provinces seven gave figures falling short of this average. They were the United Provinces, Bihar, Orissa, Bengal, Assam, the Central Provinces and Sind. On the other hand, the performance of vaccinators in the provinces of Delhi, the Punjab and the North-West Frontier Province was more than twice the average figure for British India.

18. What should be the number of vaccinators to be prescribed for specific units of rural and urban population? In determining the number of vaccinators for rural and urban areas, the wider distribution of population and the smaller facilities for travelling in rural areas, as compared with towns and cities, should be taken into consideration. Conditions vary to such an extent between individual urban centres and among villages that it is not easy to give due weight to these factors and prescribe suitable standards.

19. In the province of Madras where compulsory primary and revaccinations have been in force for some years, the Director of Public Health states that the minimum for primary vaccination is fixed at 3 to 3.5 per cent. of the population per annum in both urban and rural areas and at 6 per cent. for revaccinations. The average birth rate in the province is estimated at 40 per mille and it is stated that due allowance has been made for infantile mortality in fixing the minimum for primary vaccination at 3 to 3.5 per cent. (or 30 to 35 per mille) of the population. This provides for an infantile mortality rate ranging in different places from 125 to 250 per 1,000 live births. Even if the rate be higher in certain places, the prescribed percentage of 3 to 3.5 for primary vaccinations will probably prove satisfactory for some time because a certain proportion of older children and adults would have escaped vaccination in infancy.

20. It will be seen that primary vaccinations and revaccinations will together cover about 9 to 9.5 per cent. of the population in Madras every year, and in 10 years at least 90 per cent. will be immunised. Thereafter, the proportion will be kept at that level. In view of administrative difficulties in keeping correct records of the vaccinal condition of the adult population, a certain proportion of whom move

about from place to place, such a level of performance may be considered satisfactory.

21. A total number of 834 vaccinators was employed in the province of Madras in 1940 and the average number of vaccinations for each man was in the neighbourhood of 6,000 per year. This is the standard of performance in the provinces of Delhi, the Punjab and the N.-W. F. Province. There is no reason why the other provinces should not reach this standard. In determining the number of vaccinators required for rural and urban areas in the different provinces, the standards prescribed by the Madras Government seem satisfactory, provided the interval between revaccinations is fixed at 10 years. When dealing with the large populations of the provinces of India this interval can be accepted as reasonably satisfactory. If individual provinces were to fix the annual minimum number of vaccinations to be performed by a vaccinator at 6,000 and prescribe that, in each rural and urban vaccination circle, the annual minimum for primary vaccination should be about 3.5 per cent. of the population and for revaccination 6 per cent., it should then be easy to work out the total number of vaccinators required for the province concerned and their relative strength in the different circles.

22. We have described at some length the procedure in Madras in the hope that the information given will prove useful to other provincial authorities when they proceed to enforce a campaign of intensive immunisation against smallpox.

### **The Long-Term Programme**

23. We anticipate that, by the time the long-term programme is completed, immunisation of the population against smallpox by the enforcement of vaccination at periodical intervals will have become such an established practice as to have eliminated the disease from the country except as sporadic outbreaks resulting from the introduction of infection from outside.

24. Other factors helping towards the elimination of smallpox in an epidemic form in the community will, it is expected, also come into existence. These include, among others, better housing conditions which will help to prevent or at least reduce overcrowding as compared with the existing state of affairs, and a spirit of active co-operation with the health authorities arising out of the peoples' intelligent understanding of the purpose to be achieved by the measures instituted against the disease.

## **4. CHOLERA**

### **Introduction**

1. Certain parts of India have the reputation of being endemic areas for cholera. The Bengal delta and the basin of the Cauvery river in the province of Madras have been considered as such areas and it has been suggested by more than one health authority that epidemic outbreaks of the disease arise in these regions and spread to different parts of the country. During the nineteenth century there occurred three or four pandemics of cholera, which covered in their sweep the continent of Europe, the British Isles and even America. These pandemics have been traced to India as the place of origin. Along with smallpox and plague, cholera is another important disease against which a number of countries, with whom



India has trade relations, impose quarantine restrictions, from time to time, on passengers from this country by land, sea or air.

### The Geographical and Seasonal Incidence of Cholera

2. There is perhaps no infectious disease which shows a greater variability in its incidence from year to year than cholera. Below are given figures of cholera mortality in British India, excluding Burma, as averages for quinquennial periods from 1877 to 1941:—

Period	British India (excluding Burma) Annual average
1877-81 . . . . .	288,949
1882-86 . . . . .	286,105
1887-91 . . . . .	400,934
1892-96 . . . . .	443,890
1897-01 . . . . .	383,294
1902-06 . . . . .	367,160
1907-11 . . . . .	397,127
1912-16 . . . . .	328,593
1917-21 . . . . .	392,070
1922-26 . . . . .	143,890
1927-31 . . . . .	297,758
1932-36 . . . . .	140,440
1937-41 . . . . .	147,423

It will be observed that, in spite of the smoothing introduced by averaging in five-yearly periods, the range of variation is extensive, from about 141,000 to about 444,000. If figures for individual years were examined the variation in the figures would be found to be even higher.

3. The incidence of cholera in India varies from province to province and from year to year. The provinces, where its incidence is high, are Madras, Bengal, Bihar and the Central Provinces and, to a smaller extent, Orissa and the United Provinces. A striking feature of cholera is the regularity of its seasonal incidence in the different parts of the country; for example, in Bengal the peak of the epidemic is generally reached between March and April, in Bihar in May, in the United Provinces about June and in the Punjab in August. While it may seem reasonable to expect that modern developments in rail and road transport would facilitate the spread of the disease, a striking feature of the epidemiology of cholera is that its ostensible westward movement, as indicated by its seasonal prevalence, has, broadly speaking, remained undisturbed from the time when such facilities for travel were not available. There must, therefore, be other factors responsible for the appearance of the disease at specific seasons of the year in particular areas and, although certain explanations have been put forward, no complete and convincing answer to this question is yet available.

4. The seasonal character of the incidence of cholera does not, however, mean that its spread is not associated with large movements of population. Pilgrim centres, which attract at intervals large numbers of visitors, have, indeed, played an important part in the dissemination of the disease and, in more recent years, the enforcement of rigorous sanitary measures in connection with such festivals has become a recognised public health procedure throughout the country. We shall refer to this subject in greater detail later.

### Preventive Measures

5. In the case of cholera, as in many other communicable diseases, the main reservoir of infection is man. The patient excretes the

organism in large numbers in his stools and vomited material while it is known that, for a period varying from a few days to a few weeks after the attack, his stools continue to be infective. Such evidence as is available does not support the idea of chronic carriers of cholera infection as in the case of typhoid. It is, however, known that healthy persons in contact with patients may sometimes take up infection and, without themselves falling ill, communicate infection to others. The life of the organism is, as far as is known, of short duration in water and in the general physical environment. The common channels through which the germs are distributed have long been known to be articles of food and drink contaminated with the infective material.

6. The preventive measures fall under two main heads, (1) those which are directed towards blocking the channels of infection and (2) those which are designed to promote an increase in the resistance of the individual and of the community against the disease.

#### **Control of the spread of Infection**

Measures for controlling the spread of cholera should include:—

- (1) isolation and treatment of the patient, special attention being paid to the sterilisation of infective material and, before the necessary measures for this purpose can be carried out, to such steps as will prevent the conveyance of infection through flies or other agents to human beings or articles of food and drink;
- (2) sterilisation of common water supplies which, in areas without a protected water supply, are likely to be contaminated with cholera material; and
- (3) a general improvement in sanitation, one result of which will be to eliminate flies and other insects that play an important part in the transmission of infection.

#### **The Strengthening of the Resistance of the Individual and of the Community to Infection**

The most important measure in this connection is preventive inoculation against cholera. Other measures mainly consist of the practice of personal hygiene, including special precautions to avoid the consumption of unripe fruits and other articles likely to upset the smooth functioning of the digestive tract.

7. From our brief discussion of the cholera problem in India in the preceding paragraphs, the conclusion seems to emerge that the campaign against the disease should concentrate on its effective control and eventual elimination in those areas, which have been considered endemic foci by health authorities because a tendency has been noted for its more frequent occurrence in such areas than in others. A considerable improvement of the sanitation of these areas, including the provision of protected water supply, satisfactory disposal of nightsoil and rubbish and control of food and drink in order to ensure freedom from contamination, form the most important permanent steps for stamping out the disease. Other measures, such as isolation and treatment of patients, disinfection of infective material, preventive inoculation and the practice of personal hygiene are undoubtedly of value for controlling its spread during specific outbreaks but, in the absence of the steps necessary for securing a definite and lasting improvement in environmental

hygiene, there can be no elimination of cholera as a community disease. Further, even the success achieved by the active prosecution of the measures outlined above for controlling individual outbreaks is bound to be of a limited nature.

8. These views of ours are in conformity with the results of recent researches on cholera carried out between 1934 and 1940 under the auspices of the Indian Research Fund Association. In a survey of the results, Major-General Sir John Taylor, who was till lately Director of the Central Research Institute and Chairman of the Cholera Advisory Committee of the Association, has stated "that the point at which preventive measures should be applied is the area from which infection is primarily derived—that is in the endemic areas. The application of a long-term policy of sanitary improvement in the known endemic areas, especially directed towards dealing with the factors concerned in the maintenance and spread of cholera would, in time, result in a great reduction of risk and might even succeed in eventually eliminating infection altogether."

9. Such permanent improvements will, it may be noted, control not only the incidence of cholera but also that of other bowel diseases such as enteric fevers, dysentery and diarrhoea. Although no reasonably correct estimate of their total incidence is available it may not be far wrong to assume that these diseases may together be responsible for two or three times the number of deaths due to cholera, because the average annual registered mortalities from dysentery and diarrhoea together form about 180 per cent. of that from cholera.

10. We may now take up, for separate consideration, the different measures we have discussed above. These can broadly be divided into two groups: permanent and temporary.

#### **Permanent Measures**

11. Of these the most important is the provision of protected water supplies and of satisfactory systems of nightsoil disposal. We have suggested, in the chapters dealing with these subjects, the need for a comprehensive programme of development of urban and rural water supplies and drainage. It is suggested that, in providing these basic facilities for sanitary improvement, Provincial Governments should direct that those who are responsible for drawing up plans should, in fixing priority, take into consideration the incidence of cholera in individual villages and towns. In this way, the more important centres of cholera prevalence can be brought under control and the spread of the disease from such sources of infection prevented. We have suggested that the provision of protected water to the whole population of British India should be completed in a period of about 35 years. Side by side with this, the establishment of sound nightsoil disposal systems, on the lines indicated in the chapter dealing with general sanitation, should also be proceeded with in the provinces.

12. Simultaneously with these improvements the gradual extension, over the country as a whole, of the health organisation we have recommended should help to introduce a large measure of control over the food of the people to ensure freedom from contamination and to promote a rise in the general level of environmental hygiene. The combined effect of all these measures will be, we have no doubt,

to produce a marked reduction in the incidence of cholera and of other bowel diseases.

### Temporary Measures

13. These are mainly directed against a threatened or current outbreak of the disease. Such measures include:—

- (a) notification of cases;
- (b) isolation and treatment of the patient wherever possible, and disinfection of infective material;
- (c) sterilisation of water supplies liable to contamination and their protection against the possibility of becoming infected later;
- (d) preventive inoculation;
- (e) special health measures in respect of festival centres and other places where large gatherings of people take place periodically and
- (f) educational propaganda in order to secure the co-operation of the people in carrying out anti-cholera measures.

14. (a) *Notification of cases.*—Cholera is a notifiable disease in urban and rural areas throughout British India. Nevertheless, for reasons stated in the chapter dealing with vital statistics, notification is not, in many parts of the country, either sufficiently prompt or complete to permit of early and comprehensive action being taken by the health authorities. Without going into details it may be stated that, both in the areas under our scheme and in those outside it, the carrying out of our proposals should help to ensure that cases are reported promptly and that omissions to notify are reduced to the utmost possible extent.

15. (b) *Isolation and treatment of patients, wherever possible, and disinfection of infective material.*—Isolation of patients is an important measure but, until existing hospital accommodation increases considerably, it will be difficult to ensure their isolation to any large extent. The incidence of the disease is high among the poorer and lower middle classes of the population and, both in urban and in rural areas, housing conditions are so unsatisfactory as to make home isolation of little practical value. Further, when the disease appears in epidemic form, the number of villages affected and the number of persons attacked in individual villages may often be so high that any attempt to isolate all patients may be impossible.

16. In our review, earlier in this chapter, of existing provision for the segregation of patients through infectious diseases hospitals, we pointed out that the working of most of these institutions, although they are situated in large cities, was very unsatisfactory. There is no justification for such a state of affairs and the matter should receive immediate attention from provincial health authorities.

17. For the large number of patients, who cannot be removed to hospital, home isolation should, whenever possible, be advised by the health staff. The supply, without payment, of suitable disinfectants to such homes and to all others, where cases occur, and instruction of the patients' relatives in the proper use of these disinfectants should help to check the spread of the disease. As far as possible, the health staff should assist in the carrying out of such disinfection.

18. The provision of home treatment for cholera should also be attempted, wherever possible. It is recognised that continuous medical care including the timely administration of hypertonic saline, would be almost impossible in the home, especially when a severe outbreak results in the necessity for treating a large number of patients at the same time. Additional staff of medical and auxiliary personnel from other areas should be rushed to the affected towns and villages and every effort should be made to make such treatment available to the people. As the health programme develops, an increasing provision of staff and of institutional facilities should help to make the medical care available to the people during such outbreaks more and more adequate.

19. (c) *Sterilisation of water supplies liable to contamination and their protection against re-infection.*—The provision of protected water supplies to both rural and urban communities throughout the country is the objective to be reached as soon as possible. Until it is attained, we must look to the primary unit staff in the areas under our scheme to carry out effectively the sterilisation of water-supplies in cholera-infected villages. Where there are several sources of drinking water in such villages, it should be possible to ensure that only a few of these sources, which can be repeatedly sterilised and kept under control, are used by the people.

20. (d) *Preventive inoculation.*—The popularity of anti-cholera inoculation has been a process of steady growth. The report of a special Committee of the Central Advisory Board of Health, which investigated the question of compulsory anti-cholera inoculation of pilgrims attending festival centres, shows that, between 1928 and 1938, the number of inoculations in British India rose from about 3,400,000 to nearly 10,800,000 per year. Taking these figures and other evidence available to us into consideration, we came to the conclusion that public opinion in favour of inoculation had developed at an altogether unexpected rate. During the past two years, when the abnormal conditions arising out of the War produced widespread outbreaks of the disease in different parts of the country, millions of inoculations were carried out and there was no opposition from the people to the enforcement of this protective measure. For instance, in Bengal alone, within the period from 1st November 1943 to the end of September 1944, there were about 18 million inoculations.

21. The primary unit staff should be able to carry out, within its area, an effective immunisation of the people when an outbreak of cholera or the threat of an outbreak makes the conferment of such protection necessary. In this inoculation campaign the doctors, public health inspectors and public health nurses should all participate and thus quickly protect a large section of the population.

22. The question of permitting non-medical personnel, such as public health inspectors, to carry out preventive inoculation against epidemic diseases was carefully considered by the Central Advisory Board of Health in 1940 and its decision was in favour of their being permitted to do so under proper supervision. Since then it is understood that, in a number of provinces, the health authorities have been utilising the services of these inspectors for inoculation campaigns during epidemics. Fully trained public health nurses and even health visitors, after being suitably instructed, should be

able to carry out such inoculations. We recommend that, by frequent inspections, the two medical officers of the primary unit should exercise, especially during the early stages, adequate supervision over all non-medical personnel engaged in carrying out such inoculations, in order to ensure that efficient sterilisation and other necessary precautions are taken by them.

23. (e) *Special health measures in festival centres.*—In view of the recognition of the part which the large periodical gatherings of people at festival centres can play and have played in the spread of infectious diseases, particularly cholera, it has become a recognised practice for provincial authorities to take elaborate measures on such occasions. Considerable emphasis is laid on an improvement of the sanitation of the locality, inspection posts are established at all points where traffic converges on the festival centre by road, rail or waterway, and special provision is made for the control of food and water supplies, for medical relief, for the detection of cases of infectious diseases and for the proper segregation and treatment of such cases. In addition to these measures, it has been found useful to enforce the compulsory inoculation of persons against cholera before they are permitted to attend festivals. In 1940 the Central Advisory Board of Health, after carefully considering the report of a special committee which it had appointed to investigate this question, gave its blessing to the proposal that health authorities in India should adopt this additional precautionary measure in festival centres. Later the efficacy of this measure was again tested at the Sitamarhi festival in Bihar, and excellent results have been reported. In these circumstances, while recognising that all the other measures indicated above are necessary in order to ensure the health of the pilgrim population, we would endorse the recommendation of the Central Advisory Board of Health and suggest to Governments the desirability of enforcing compulsory inoculation against cholera before a pilgrim is permitted to attend any specific festival, whenever the possibility of an outbreak of the disease cannot be ruled out.

24. (f) *Educational propaganda.*—While all the measures outlined above are undoubtedly valuable, the extent of their usefulness will be largely determined by the amount of co-operation that can be secured from the people. Intelligent co-operation can be based only on a full understanding by them of the purpose underlying the measures and on their acceptance of the need for their enforcement. Educational propaganda constitutes, in our view, the most efficient means of securing the support of the people, and such propaganda should, therefore, form an important part of our anti-cholera programme. The war against disease and dirt will have been half won if the community can go forward to the fight armed with sufficient knowledge to enable each individual to fulfil his or her part with zeal and effectiveness.

25. We recognise that an anti-cholera campaign on the lines outlined above can be carried out more effectively in the areas where our scheme will operate than in those not included in it. The suggestions we have made, earlier in this chapter, for increasing existing provision for medical relief and for facilitating control measures against epidemic diseases through the establishment of travelling dispensaries and of epidemic squads will, it is hoped, help to

promote the carrying out of anti-cholera measures in a more efficient manner than has been possible in the past.

## 5. PLAGUE

### The Incidence of Plague

1. Plague was introduced into Bombay from China in 1896 and, within a few years, it spread widely through the country. Its maximum incidence was reached in 1904 with a registered mortality of 1,144,000. Since then, a steady reduction in its prevalence has taken place, the past decade or more having witnessed a considerable fall in the annual mortality from this disease. The figures given below, which are quoted from the Preliminary Report of the Public Health Commissioner with the Government of India for 1939, indicate clearly this decline in the incidence of plague:—

#### British India

Period	Total plague deaths	Figures in column 2 expressed as percentage of total deaths during 1898—1938	Annual average
1	2	3	4
1898-1908 . . . . .	6,032,693	49	548,427
1909-1918 . . . . .	4,221,528	34	422,153
1919-1928 . . . . .	1,702,718	14	170,272
1929-1938 . . . . .	422,880	3	42,288
	12,379,819		

The average annual mortality from this cause during the three years 1939, 1940 and 1941 was only 19,347 or 45.7 per cent. of the corresponding average for the ten-year period 1929—38.

2. *The epidemiology of plague.*—While this continued decrease in the incidence of plague is no doubt gratifying, it must be remembered that this decline has not been brought about by the effectiveness of any specific measures undertaken for its control. The history of plague in India and elsewhere clearly indicates that the prevalence of the disease, during certain periods, increases considerably both by an extension of its geographical distribution and by a rise in its incidence in individual places, while at other times there occurs a diminution of the disease, through a rapid contraction of the territory covered and a marked decrease in the number of cases occurring in the affected areas. In India too, both these changes have characterised the marked decrease in the incidence of the disease during recent years.

3. Plague is primarily a disease of certain rodents and human infection on an appreciable scale takes place only under conditions favouring close association between man and such rodents. In certain parts of the world, plague infection among such animals never dies out and these constitute endemic areas from which infection spreads to other regions from time to time. In India the animal is the rat while in South Africa it is the gerbille, in California the ground

squirrel and in South-eastern Siberia and Manchuria it is the tarbagan. Periodically outbreaks of the disease take place on a large scale among such animals and destroy large numbers of them. For a time the infection lies dormant but, when the animals breed and a large susceptible group is produced, an epidemic wave starts again.

4. Man becomes infected from such animals through the bite of the fleas which live and feed on them. Without going into details regarding the mode of transmission of infection it will be clear that opportunities for close association between man and the special rodent responsible for keeping alive plague in the area concerned is a fundamental factor for the production of the disease in human communities. Widespread outbreaks among such animals may lead to territorial extensions of plague while the transportation of infected rats or infected fleas through grain traffic or in other ways may result in the starting of the infection in areas far removed from the endemic foci of the disease.

Lieut.-Colonel S. S. Sokhey, I.M.S., Director, Haffkine Institute, Bombay, who has for many years been associated with plague research, considers that a number of such endemic centres exists in India.

5. Plague appears in two main forms, bubonic and pneumonic. The former is characterised by the development of buboes or swellings in the groin, arm-pit or neck of the patient and, although it is the less severe form of the two, the rate of mortality may be as high as 60 to 70 per cent. among those who are attacked. It is in the transmission of bubonic plague that the rat and certain types of rat fleas play their part. Pneumonic plague is a form of severe pneumonia set up by the plague germ and its infection is conveyed from person to person through the air. The chance of any one in contact with a patient contracting pneumonic plague is very high and the rate of mortality is practically cent. per cent. The large majority of plague cases occurring in India is of the bubonic type. Occasionally, through causes which remain largely unexplained, a case of pneumonic plague starts in the midst of a bubonic outbreak and then it runs a rapid course killing off all those who are attacked. In India such outbreaks of pneumonic plague have been so far strictly limited in the extent of their prevalence, a termination being reached with the extermination of the specific group exposed to infection. In colder countries such as Siberia, the disease may start with a limited number of bubonic cases, but plague pneumonia soon appears on the scene and the subsequent spread of the disease has often been rapid and extensive, with the result that thousands have succumbed to it during specific epidemics. Probably the climate is an important factor in determining the type of plague. Greenwood\* states that, in the fourteenth century, plague as it spread slowly across Europe, exhibited the tendency to become pneumonic in the winter and to change to the bubonic form when the weather grew warmer.

6. *Anti-plague Measures.*—In India bubonic plague is the disease with which we have mainly to deal. As this form of plague is essentially a disease of rats in this country and as cases in human beings occur through the transference of infection from rats to man, the most important preventive measure in regard to the control of this

\* "Epidemics and crowd-diseases" by Major Greenwood.



disease is the keeping down of rats in residential areas, which must help to prevent the occurrence of widespread outbreaks of rat plague as well as to reduce the chance of infection spreading from rats to man. When an outbreak of human plague is imminent or has actually taken place, other measures will also be necessary in order to protect the community concerned and these will include such steps as preventive inoculation, the evacuation of people from infected localities or houses and the provision of adequate treatment for patients. All these measures against plague should, as in the case of cholera, be enforced intensively in the endemic centres of the disease in order to secure definite control over its incidence and later its eradication, if possible.

7. The necessary measures may broadly be divided into two groups, permanent and seasonal. The former include:—

- (1) construction of rat proof dwellings and rat proof grain stores and railway godowns;
- (2) control over the location of certain trades and industries which attract rats and
- (3) an improvement of the general sanitary condition of towns and villages.

All these measures are meant to keep down the rat population. We shall deal with them separately.

#### **Rat-proofing**

8. (a) *Dwellings*.—In the Netherlands East Indies, the authorities have promoted the construction of a simple type of rat-proof dwelling by means of type plans and grant of subsidies. This measure is said to have had considerable influence on the control of plague in that country. In the Cumbum Valley in Madura district of Madras Presidency, experiments were in progress for a number of years, under the auspices of the Indian Research Fund Association, and a type of hut, suited to village conditions, has been evolved. It costs less than Rs. 100 and has been shown by close observation to have remained free from rats for two years. The popularisation of such a type of dwelling should prove helpful in the campaign against plague.

(b) *Grain stores*.—Rat-proofing of grain godowns is of special importance. At least in certain provinces local authorities possess, under the Local Self-government Acts, power to regulate the storing of grain for sale to the public. They should use these powers to ensure that such grain stores are not located in congested areas and that they are rendered rat-proof. It will also be of advantage if suitable stores and retail shops can be constructed by local authorities and rented out to grain merchants. By combining the enforcement of law with the provision of properly constructed stores from public funds it should be possible to control the grain trade in such a manner as to reduce effectively the danger which it now constitutes in places liable to outbreaks of plague.

Storage of grain in private houses should also be controlled. In different parts of the country various types of bins and methods of storage are in use. It may not be possible to provide a single type suitable for use throughout the country; it is, therefore, suggested that provincial health authorities should, in consultation with their

local officers, prepare plans for a number of types of storage vessels and induce the people to use them.

The conversion of existing granaries into rat-proof stores should also be carried out on the lines approved by local health authorities.

(c) *Railway premises*.—It is equally important to provide rat-proof godowns in railway premises. Grain and other material likely to attract rats are stored for varying periods at railway stations, thus increasing the chances of plague infection.

In all grain stores for wholesale and retail sale and in railway premises it is essential that, in addition to rat-proofing, measures for the destruction of the rats that may be introduced in spite of all precautions, should also be carried out continuously. Local health authorities should make suitable legal provision for the enforcement of this measure and should ensure that it is carried out effectively.

### **Location and Control of certain Trades and Industries**

9. Local authorities have power, under Local Self-government Acts, to regulate the location and the carrying out of a number of trades and industries which are likely to attract rats. For instance, the Madras District Municipalities and Local Boards Acts give to municipal and non-municipal health authorities the power to regulate a number of trades of which the following are examples:—

- (a) Washing soiled clothes and keeping soiled clothes for the purposes of washing them, and washed clothes;
- (b) boiling paddy, or camphor;
- (c) melting tallow or sulphur;
- (d) storing or otherwise dealing with manure, offal, blood, bones, rags, hides fish, horns or skins;
- (e) washing or drying wool or hair;
- (f) making fish-oil;
- (g) making soap, dyeing, boiling or pressing oil, making bricks, tiles, pottery or lime;
- (h) manufacturing or distilling sago; manufacturing artificial manure;
- (i) keeping a public halting place, choultry or other rest-house for travellers, a hotel, restaurant, eating house, coffee house, etc.;
- (j) preparing flour or articles made of flour for human consumption or sweetmeats;
- (k) selling grain or jaggery wholesale or storing grain or jaggery for the wholesale trade;
- (l) manufacturing jaggery or sugarcandy.

It will be seen that many of these trades, if carried on without due care, will provide abundant food to rats and will, therefore, help to increase their numbers. The location of many of these trades in densely populated areas should be discouraged, specially in regions where plague is endemic. If, however, these trades are permitted in such areas, due precautions should be enforced in order to keep down the rat population.

10. *Improvement of general sanitation*.—The throwing of garbage in public places encourages the breeding of rats by providing them

with food. A general improvement in the sanitation of rural and urban areas will, therefore, be an important contribution to the campaign against rats.

### Seasonal Measures

11. Temporary measures include (1) rat destruction, (2) a periodical cleaning of homes, (3) control of movements of goods, particularly grain, (4) preventive inoculation, (5) evacuation of infected houses or localities and (6) treatment of patients.

12. *Rat destruction.*—Of recent years the most effective method of rat destruction has been found to be through the use of cyanogas. It has been shown that fumigation of rat holes by cyanogas year after year constitutes an effective method of reducing the incidence of plague in endemic areas. Under the auspices of the Indian Research Fund Association cyanogas fumigation was carried out in Cumbum Valley over a number of years in order to determine its value as an anti-plague measure. The Plague Advisory Committee of the Association, after reviewing the results in December 1940, came to the conclusion that cyanogas fumigation operations, systematically carried out in the infected and threatened villages during the previous six years, had been mainly responsible for the marked reduction in the incidence of plague in this endemic area. We, therefore, recommend strongly the adoption of this measure in all endemic centres of the disease.

13. *Periodical cleaning of homes.*—A periodical cleaning of the house, particularly during the weeks preceding the plague season in the locality concerned, is a salutary measure in areas liable to outbreaks of the disease. The turning out of the contents of the house and exposure to the sun of bedding, clothing, furniture and other articles will help to disturb the rat population and to kill off the fleas.

14. *Control of movement of goods particularly grain.*—The part that grain traffic plays in the transport of plague infection, from plague stricken areas to those which are free, is well known. In regions, in which the disease is endemic, an attempt should be made by the local health authorities to study normal movements of grain and to ascertain the areas to which it is ordinarily transported in each month of the year. When such information is available it should be possible, by administrative measures, to ensure that grain known to be emanating from infected villages is examined and dealt with properly (e.g. cyanogas fumigation) before being sent out. In this connection, the closest possible co-operation between local health and railway authorities will be necessary.

15. *Preventive inoculation.*—As in the case of cholera inoculation, the popularity of plague inoculation has steadily increased. The Director of the Haflkine Institute, Bombay, who is responsible for the manufacture and issue of plague vaccine for use throughout India, has pointed out that, in spite of a continued fall in the incidence of plague, the demand for plague vaccine has increased. When an outbreak of plague is imminent or when the disease is actually prevalent, preventive inoculation is the one measure which should be carried out with the greatest possible vigour.

16. *Evacuation.*—Evacuation of the residents from a house in which a rat fall has taken place and disinfestation of the house and its belongings constitute important measures against the disease.

Further, if rat falls occur in a number of houses in any locality, evacuation of the whole area is desirable. It may, however, be pointed out that the procedure generally adopted for the removal of people from infected areas is, in many cases, unsatisfactory. Their removal should be accompanied by adequate measures to destroy rats and fleas in the personal belongings and other goods of these people in order to prevent the transmission of infection. Such disinfection is, however, often carried out perfunctorily with the result that plague infection is conveyed, on occasions, to the newly occupied areas. Secondly, as plague usually occurs in the colder part of the year, a compulsory transference of groups of people from well-settled homes into temporary quarters is bound to create opposition unless the new premises provided for them afford reasonable comfort. This requirement has hardly been met on many occasions. Thirdly, the camps to which the people are removed are not often located sufficiently far from their original homes to prevent journeys to the infected locality being made surreptitiously at night. We consider it necessary to draw special attention to these facts because we feel that, if evacuation is to produce the intended results, it is essential to ensure the carrying out of the required measures on proper lines.

17. *Treatment of patients.*—Till recently, there was no specific treatment for plague and the efforts of the physician were mainly directed towards giving relief to the patient and to the keeping up of his strength in the fight against the disease. The manufacture of a potent serum has been attempted by more than one investigator in different countries. A few years ago, the Director, Haffkine Institute, prepared a serum which, on field trial, was established to be definitely more effective than the ordinary form of treatment. Sulphapyridin and sulphathiazole have also been found to be useful in the treatment of plague. Of the two, sulphathiazole is considered the better drug because its effectiveness is probably a little higher and its toxicity less.

## 6. LEPROSY

1. The subject of leprosy in India and its control was examined in great detail in October 1941 by a Special Committee, which was appointed by the Central Advisory Board of Health, and its report contains a large amount of valuable information which we have freely utilised in the preparation of this section.

### **The Incidence of Leprosy in India and its Geographical Distribution**

2. Census enumerations of leprosy patients have always been serious underestimates of the real incidence of the disease. The latest available enumeration (for 1931) places the figure for India as a whole in the neighbourhood of 150,000, an advance of about 50 per cent. on the 1921 enumeration. On the other hand sample surveys carried out by specially trained medical men in different parts of the country have shown that, for the areas concerned, the actual numbers of leprosy patients are many times the figures recorded at the 1931 census. Basing its calculations on the results of these surveys the special Committee referred to above estimated that the number of cases of leprosy in the country "is probably at least one million". It should, however, be remembered that a high proportion of this total figure consists of non-infective cases, these being as high as

70 to 80 per cent in most parts of India. Even so, infective patients may well be in the neighbourhood of a quarter of a million in the whole country.

3. The highly endemic areas of leprosy in India are certain parts of Western Bengal, of Orissa and of Madras. Broadly speaking, the incidence of the disease is high in a belt of territory covering the southern portion of the peninsula, including Cochin and Travancore, and the east coast of India. A belt of moderate incidence runs across Northern India along the Himalayan foot hills, while Central India also shows a moderate prevalence of the disease together with certain foci of higher incidence. In North-Western India, including parts of the United Provinces and the Punjab, Rajputana, Sind, Baluchistan, North-West Frontier Province, Gujerat and the northern part of the Bombay Province, the incidence of leprosy is remarkably small.

4. In the highly endemic areas its incidence may range from two to five per cent of the population. In restricted areas in such endemic regions the proportion of cases may rise to 10 per cent of the population while individual villages may show a rate as high as even 15 to 20 per cent. In the non-endemic regions of North-Western India, on the other hand, large areas may show no cases at all while the general level of incidence is stated to be as low as 0.01 per cent or one per ten thousand of the population.

5. The public health aspect of the leprosy problem in an area is determined not merely by the rate of incidence of the disease in the population but also by the relative severity and infectiveness of individual cases. Cases of leprosy are broadly divided into two groups, the "neural" and "lepromatous" types. The former constitutes the "benign" form of leprosy and, as pointed out by the International Leprosy Congress, 1938, "these cases give evidence of relative resistance to the infection, or of relatively good prognosis as regards life although mutilation may take place . . . . Bacteriologically the skin lesions are typically but not invariably found negative by standard methods of examination, though the nasal mucosa may be found positive." The lepromatous type consists, on the other hand, of the "malignant" form of leprosy, "in which the patient is relatively non-resistant, has a poor prognosis and exhibits lepromatous lesions of the skin and other organs, especially the nerve trunks. Bacteriological examination usually reveals abundant bacilli." It is therefore the lepromatous case that is usually much more infective than the neural case. While for the country as a whole the proportion of lepromatous cases is estimated at about 20 per cent of the total number of leprosy patients, there are areas where the proportion of this severer type is as low as 4 per cent and others in which it rises even to 50 per cent. The Committee has stated that "it is unusual in India to find an area where leprosy is both very common and severe. In Bengal, Bihar, Orissa and in the north-east part of the country in general, leprosy appears to be relatively common and relatively mild. In the foot hills of the Himalayas and in the areas to the north west, leprosy is relatively rare and severe. In the south, *e.g.*, Madras, leprosy is very common but also more severe than in the north-east, though less severe than in the Himalayan foot hills." In estimating the importance of leprosy as a public health problem the rate of incidence and the

relative proportion of the lepromatous type should both be taken into consideration.

6. Two other aspects of the leprosy problem should also be considered in connection with a survey of the incidence of the disease in the country. These are (1) leprosy among beggars and (2) industry in relation to the disease.

### **The Problem of Beggars with Leprosy**

7. Beggars with leprosy are found in varying numbers in a large number of towns and cities, in places of perennial pilgrimage and in all centres where pilgrims congregate periodically. The Special Committee has pointed out that, in Calcutta, there are about 1,000 beggars with leprosy, most of them having come from other provinces, and that the profession of begging has been organised by them to a high degree of perfection under a headman. Many of them are married to persons who are also suffering from leprosy and the quarters occupied by them are usually separated from those of the general population. In religious centres the common custom of giving alms to beggars and the frequent feeding by charitable persons constitute incentives which help to concentrate them in relatively large numbers. The large majority of these beggars are leprosy patients. While a certain proportion of them are burnt out cases and are non-infective, the Committee point out that "the statement not infrequently made that almost all beggars with leprosy are not infective is not true."

### **Leprosy in relation to Industry**

8. The Committee has thus briefly stated the problem:—

"During recent years some evidence has been accumulating to show that the development of industry is probably having an influence on the spread of leprosy and the possibility of this increase must be borne in mind. Leprosy surveys of industrial workers have been carried out in various parts of India and an incidence of between 1 and 2 per cent has often been found, and a considerable number of cases have been infective cases. The presence of these infective cases in the crowded *busties* and living quarters of industrial workers is a definite menace to the other workers and their families. The fact that the industrial population of India is largely migratory increases the menace to public health. Not infrequently in village surveys one comes across patients with leprosy who attribute the disease to having been infected while working in industrial centres. Sometimes such a patient having contracted the disease in an industrial centre, will return to his village and introduce the disease there where it was not previously found".

The question of dealing with these two aspects of the leprosy problem will be considered later in this chapter.

### **Existing Anti-leprosy Work in India**

9. Existing anti-leprosy work is being carried out largely by voluntary organisations although, in recent years, Provincial Governments have begun to show an increasing interest in the promotion of this branch of health activity.

10. The Mission to Lepers, which was founded by Wellesley Bailey in 1875 with its first leper institution at Chamba in the

Punjab, is the largest agency engaged in anti-leprosy work in the country. At the time of his death in 1937 there were 32 institutions under the Mission in India and these housed 8,000 patients. Further, the Mission gave financial aid to 17 other institutions which provide for 2,600 additional patients. Besides those maintained by this Mission 16 other institutions are maintained by different Christian Missions. Lately Provincial Governments and even local bodies (district boards and municipalities) have started the establishment of in-patient accommodation for leprosy. Nevertheless, the Committee estimated that the total accommodation available for the segregation and treatment of patients of this disease was only about 14,000 for the whole country.

11. Another organisation which requires special mention is the Indian Branch of the British Empire Leprosy Relief Association, which was established in 1925 with funds derived from a public appeal by the Viceroy of India. This Association has actively helped in the organisation and carrying out of leprosy research, the provision of facilities for special training for doctors in the diagnosis and treatment of the disease, propaganda and co-ordination, through its provincial branches, of governmental and voluntary effort in the campaign against leprosy.

#### **Certain Points to be considered in Planning an Anti-leprosy Campaign**

12. Certain points require consideration in connection with the planning of an anti-leprosy campaign. They include the following:—

(1) Although leprosy is a communicable disease its rate of spread is relatively slow in comparison with such diseases as cholera, smallpox, plague, malaria and tuberculosis.

(2) The exact mode of transmission of leprosy infection is not known but it has been recognised that prolonged and close contact between the infective patient and a healthy individual is necessary before the latter becomes infected. It has also been recognised that children are more susceptible to the disease than adults. A child born of an infective leprosy patient and removed at birth does not develop the disease. On the other hand such children, if not separated from their infected parents, acquire the disease in a large proportion of cases. Evidence has been cited to show that the rate of infection may be as high as 80 per cent. Adults similarly exposed to infection (for example the wife of an infective husband and *vice versa*) contract the disease to a much smaller extent, the proportion of those developing leprosy being only about 5 to 10 per cent.

(3) The infective patient may not often be easily recognised. Those in an advanced stage and with deformities may often be non-infective while others with no easily recognisable outward signs of the disease may prove, on close examination, to be infective. In a broad sense it is true that it is the more severe lepromatous type which usually possesses a high degree of infective power.

(4) Isolation of the infective patient is the one measure which is advocated by all leprosy workers throughout the world as the most effective method for controlling the spread of the disease. An anti-leprosy campaign must therefore place the isolation of infective patients in the forefront of its programme. The fact that the number requiring isolation in the country as a whole may well be about 250,000 and that the period of isolation necessary for individual

patients may extend to many months or even years makes the adoption, on a sufficiently wide scale, of this universally accepted method of control by no means easy. This does not, of course, mean that no steps of definite practical value can be taken in this direction in the immediate future.

(5) The value of treatment as a preventive measure in leprosy is much more limited than in many other infectious diseases, in which a cure or an effective arrest of the spread of infection in the patient (e.g., tuberculosis) may be established and the individual rendered innocuous as a transmitter of the disease. Treatment has, however, its place in the anti-leprosy campaign and we shall refer to it later.

### OUR RECOMMENDATIONS

13. If the development of anti-leprosy work is to proceed on sound lines the plan should, in our opinion, make provision for:—

- (a) the investigation of leprosy as a public health problem in local areas;
- (b) the organisation of curative and preventive measures in those areas in which the prevalence of the disease is shown to be sufficiently high to require such measures;
- (c) The stimulation of voluntary effort to supplement the work accomplished by the public authority and
- (d) education of the public in order to secure their intelligent co-operation in the anti-leprosy campaign.

14. As an essential step towards the attainment of the purposes indicated under (a) and (b) above, provision will have to be made for special training in the diagnosis and treatment of leprosy at the undergraduate and postgraduate stages of medical education and for the active promotion of leprosy research. It will be recalled, in this connection, that in the chapter on professional education we have specially drawn attention to the need for such provision, and in order to provide post-graduate teaching and research facilities of a high order, we have recommended the creation of a Central Leprosy Institute in an area with abundant suitable clinical material and have further suggested that the Central Government should assist in its establishments and maintenance. We shall deal with the organisation and functions of this Institute in some detail later in this chapter.

15. In order to promote anti-leprosy work on the lines indicated under (a) to (d) above we put forward the following proposals for the short-term programme. While recognising that they can only be considered as the first step towards the solution of the leprosy problem, the magnitude of which we fully realise, we believe that they will constitute, if implemented, a substantial advance on the measures that are now in force for the control of the disease.

- (1) The creation of Provincial Leprosy Organisations.
- (2) An increase of the existing provision for institutional treatment, out-patient and in-patient.
- (3) Development of group isolation colonies.
- (4) Substantial financial help to voluntary organisations engaged in anti-leprosy work.

### The Provincial Leprosy Organisation

16. We have already mentioned that by far the largest proportion of anti-leprosy work in the country is now being carried on under the



auspices of voluntary organisations. While fully recognising the value of voluntary effort in this and in other fields of health activity, we must emphasise the view that the primary responsibility for taking adequate measures against the disease should rest on Governments. We find that we are supported in this opinion by the Fourth International Conference on Leprosy at Cairo in 1938, which pointed out that the control of leprosy should be "the inescapable responsibility of the Governments concerned". We therefore consider it essential that, as a preliminary step towards organising provincial anti-leprosy work on sound lines, a leprosy organisation should be created at the headquarters of each province in which the disease is a definite public health problem. This leprosy organisation should be an integral part of the provincial health service. The special Committee has pointed out that, in the past, when provincial authorities have shown some interest in, and responsibility for, anti-leprosy work, "they have often done so in a half-hearted way. They have appointed a very small poorly paid and sometimes poorly qualified staff". The Committee went on to say that in the Philippine Islands and Japan "leprosy workers are Government servants—well qualified, well trained, specially chosen for the work and given excellent status, pay and prospects, at least equivalent to those of similar men in medical and public health departments". We desire to see a similar policy followed in India also. The provincial leprosy organisation we are recommending (details will be found in appendix 10) will be controlled by a Provincial Leprosy Officer attached to the establishment of the Director of Health Services. This Officer should have had, besides special training in leprosy, considerable experience in organising anti-leprosy work in its different branches, including survey, out-door and in-patient treatment of leprosy patients and the development of measures for group isolation of infective patients through village colonies. He will be assisted by a suitable number of assistants to promote preventive and treatment work on the lines indicated above. Epidemiological field investigations in close association with laboratory research form an essential part of an anti-leprosy campaign on sound lines. Provision for these should therefore form a part of the proposed provincial organisation. The suggestion we have made (see Appendix 10) for the composition of such an organisation will, of course, be subject to the needs of individual provinces and should be modified in relation to them.

#### **An Increase in the Existing Provision for Institutional Treatment, Out-patient and In-patient**

17. It seems appropriate to begin with some remarks regarding the value of leprosy treatment. Special treatment for the disease is through the administration, usually by injection, of some preparation of *Hydnocarpus wightiana* or *chaulmoogra* oil. Additional treatment, medical and surgical, is also given to deal with special conditions as they arise. About twenty or twenty-five years ago striking results were claimed as the result of *Hydnocarpus* oil treatment and great expectations were aroused in regard to the control of the disease through a wide expansion of treatment facilities. These expectations have not, however, been fulfilled because it became recognised, after some years, that this treatment has but limited value in arresting the progress of the disease. It has been found that, in many of the "benign" cases, the improvement noted in treated patients often takes place in untreated cases also. Further, Dr. R. G. Cochrane, who has

had considerable experience of anti-leprosy work in this country, has pointed out in a memorandum submitted to us that "even with modern methods of treatment about 60 to 85 per cent. of all persons who suffer from lepromatous leprosy do not recover sufficiently for them to return to work, and the great majority of these remain infective". Treatment has therefore a limited value. While recognising this, we still hold that the provision of treatment facilities has a place in the campaign against leprosy. Apart from such relief as it may give, the co-operation of patients and their relations cannot be secured in the measures against leprosy without providing treatment. By the establishment of treatment centres it will be possible to attract patients and then, through investigation in their homes and through the information supplied by them, to discover the extent of leprosy infection in the area concerned. Educational propaganda and other preventive work can also be carried out more effectively when such co-operation is available. Moreover, surgical and medical treatment in respect of various conditions as they arise afford some relief to the patient even if the progress of the disease cannot in all cases be effectively checked. The provision of treatment facilities should therefore definitely form a part of the anti-leprosy programme.

#### **Out-patient Treatment**

18. At present such treatment is available in (1) leprosy clinics in association with general hospitals, (2) special leprosy clinics and (3) the out-patient departments of leprosy hospitals. Of these the Special Committee considered that the work done at the clinics under category (1) was in many cases of poor quality because the doctors concerned lacked special training in leprosy and because insufficient attention was paid to this disease owing to other heavy duties in the hospital. Special leprosy clinics are generally under the charge of doctors trained for the diagnosis and treatment of leprosy but these medical men are often ill-paid and entrusted with the charge of too many centres to give effective attention to any of them. The out-patient departments attached to large leprosy institutions are, in the opinion of the Committee, providing the best form of treatment partly because the doctors in charge are specially trained for the work and partly because the laboratory and other facilities of such institutions can, to some extent, be made available to those who are treated in the out-patient department.

19. The leprosy clinic should perform the dual role of spreading remedial and preventive care among the people in the same manner as the tuberculosis clinic in the campaign against that disease. In order to ensure that these functions are performed satisfactorily it is essential that the medical officers in charge of all leprosy clinics, whether they work independently or in association with hospitals, should have had special training in the diagnosis and treatment of the disease. Further, there should be provision for follow-up in the homes of the patients. Their contacts should be persuaded to attend the clinic for examination and suitable treatment and advice, where necessary. We have already pointed out that children are much more susceptible to leprosy infection than adults and every effort should be made, during home visits by the doctor and the nurse, to impress this fact on the people and to secure, that, as far as possible, children are safeguarded from possible infection by the carelessness of infective patients.

20. We recommend that a start should be made by providing a properly equipped and staffed leprosy clinic in association with every hospital we have proposed at the secondary health centre in those parts of the country in which the prevalence of the disease justifies such provision. In addition, as these clinics are most needed in close proximity to the areas in which the incidence of the disease is high, the provincial leprosy organisations we have recommended should survey the needs of such areas and formulate schemes for the provision of an adequate number of such clinics. In many of the highly endemic centres of leprosy a certain number of these clinics already exist and the immediate need is to staff and equip them properly and improve the quality of the work they have been doing.

### **In-patient Accommodation**

21. Existing provision for the treatment of persons suffering from leprosy as in-patients in hospitals is, as we have pointed out, limited to about 14,000 beds while infective cases requiring isolation may well be about a quarter of a million. If an effective control is to be exercised over the spread of the disease it will be necessary to provide for the segregation of the vast majority of infective cases, many of whom may require, because of the severity of their illness, admission and treatment in a leprosy hospital. Indeed the pressure on existing hospital accommodation is so high that "practically every leprosy institution in the country is full, and thousands of applications have to be refused every year for lack of accommodation". The need for a considerable increase in the existing provision for the in-patient treatment of the disease is therefore evident. We propose that, in the first five years of our programme, an additional 14,000 beds should be provided to supplement the existing accommodation and that, in the next five years, an equal provision of another 14,000 beds should also be made.

22. The Special Committee's remarks regarding the lines on which leprosy institutions should be developed are pertinent and are quoted below:—

"Local authorities and Provincial Governments have in the past tended to build leprosy institutions in or near towns and somewhat on the lines of general hospitals, with large wards housing numerous patients and with limited land. Missions have, however, built their institutions chiefly in rural areas on larger pieces of land and the patients have been housed in small numbers in small rooms or else in cottages.

"The disadvantages of the hospital type of institution in or near a town have long become apparent, and the modern tendency is to develop leprosy institutions more on colony lines and well outside towns, the patients often being housed on the cottage principle."

23. Two types of institutions are needed. One is for the isolation and active treatment of infective patients and the other is for those who are so disabled through crippling and deformities as to require institutional care. The latter are generally non-infective and therefore not dangerous from the point of view of spreading the disease. But they are often homeless, poor and unable to take care of themselves and the provision of asylums for such incurables is dictated by humanitarian considerations. We are not in a position to indicate how the proposed extension of hospital accommodation should be

distributed between these two types of patients. We have not even attempted to suggest in what manner the new beds should be allocated between the provinces. We have little information before us regarding the incidence of the disease in different areas and the relative proportions of active infective cases and incurables in these areas and, in the absence of such information, we must leave it to the Provincial Governments concerned to work out, in mutual consultation, where necessary, the extent of provision to be made in their respective territories. In developing such hospitals it may be of advantage for neighbouring provinces, *e.g.*, Bihar and Orissa, to pool the available resources and establish joint institutions to serve the needs of their peoples.

### Development of Group Isolation

24. The special Committee has pointed out that, in the past, the isolation of leprosy patients in their own homes was widely practised by the people in India but that the tradition has gradually weakened in the country as a whole and that it survives, as an effective measure only in one or two isolated parts of India, an example being the Kangra valley in the Punjab. Although attempts have been made to revive the practice, the Committee considers that the results have been disappointing and that "from the experience so far gained, it cannot be said that home isolation holds out much prospect of being widely and properly practised".

25. On the other hand the Committee advocates the investigation of the possibilities of group isolation. In this connection certain points to remember are that the period of isolation will be long, perhaps years, that provision should be made for medical care although it may not be of a very high standard, that the scheme if it is to be widely adopted should be sufficiently cheap to suit the economic level of the country and that provision should be made to promote corporate life in the isolated community and to enable the more able-bodied members of it to work and contribute towards the maintenance of the colony. We give, in this connection, extracts from the Public Health Commissioner's annual report for 1936 as Appendix 18 in which are described a successful experiment of this nature at Uzuakoli in Africa and a more modest rural experiment in the Central Provinces, both of which were under the auspices of Missionary bodies. From a memorandum submitted to us by Dr. Dharmendra, who is the Leprosy Research Officer under the Indian Council of the British Empire Leprosy Relief Association, we understand that a large-scale rural leprosy isolation scheme will be shortly inaugurated in Bankura district of Western Bengal, where the disease is widely prevalent. He says, "It is essential to work in a selected area of a reasonable size, try to isolate almost all the infective cases, and watch over a number of years the effect of this isolation on the spread of the disease in the area. The British Empire Leprosy Relief Association, Indian Council, is proposing to organise such a centre in connection with its Leprosy Investigation Centre, Bankura. The area under the Bankura Investigation Centre appears to be specially suited for this kind of work, since in this area we possess definite information about the incidence of leprosy for the past 8 years. In this area we definitely know that for all these years there has been no tendency for the disease to decrease. If the isolation of a large majority of infective cases in this area is followed by a decline in the disease we can be

sure that the decline is attributable to isolation." The results of this experiment will be awaited with interest.

26. Individual schemes for group isolation can perhaps be developed with advantage for a number of villages in which leprosy is prevalent. Such schemes will require careful working out taking into consideration local conditions, including the habits of the people. That they will occupy an essential place in the anti-leprosy campaign is unquestionable because they alone can provide for the isolation of the large numbers of patients requiring segregation. We consider experiments on these lines so important that we have suggested an annual expenditure of three lakhs on the development of group isolation during the first ten years.

### **Financial Help to Voluntary Organisations**

27. Voluntary agencies, particularly missionary bodies, have so far contributed more to the development of anti-leprosy work in India than public authorities. We have recommended a wide expansion of measures against the disease which will be the responsibility of Governments and of local health authorities. We have no doubt that, even with such expansion, it will be necessary for voluntary effort to continue unabated in this field and have therefore suggested provision to the extent of 187.5 lakhs during the first ten years to subsidise such efforts.

### **The Central Leprosy Institute**

28. Our proposals for the organisation, maintenance and control of this and of similar institutions for certain other diseases have been set out in the section dealing with post-graduate medical education. Its function will include the training of leprosy workers, the active promotion of research in this subject and the development of an information service providing the latest information regarding the treatment of the disease and anti-leprosy work in general for the benefit of Governments and organisations interested in leprosy in India. It should assist Provincial Governments in the development of their campaign against the disease, if so desired. It should be located in an area which provides suitable clinical material in abundance and should have, attached to it, a large leprosy hospital together with its out-patient department and a group isolation colony. The development of clinical research and field investigations, as distinct from laboratory studies, should be an essential part of its duties.

### **The Leprosy Problem among Beggars**

29. The two problems of mendicancy and of leprosy in this class of persons are so closely connected that it is doubtful whether the question of leprosy can be isolated and dealt with satisfactorily. The subject of mendicancy goes beyond the scope of the enquiry which we have undertaken. Yet some attempt to control leprosy in this class of people is urgently required. We have already referred to the beggars with leprosy in Calcutta. While their voluntary living together in quarters isolated from the general community does minimise to a large extent the possibility of the spread of infection except among themselves, a disquieting feature is that many of them are married and are rearing families so that, with the high susceptibility of children to the disease, the group is gradually becoming infected in an increasing degree as time goes on. Moreover

in Calcutta and in all other centres where beggars with leprosy concentrate, *e.g.*, places of perennial pilgrimage, it is likely that comingling takes place to some extent between them and those belonging to the lower economic strata of the general population. Such contact is bound to help the spread of the disease. The complicated nature of the problem, including its local characteristics in specific areas, makes it desirable in our opinion to leave it to provincial health authorities to work out plans for anti-leprosy work among this class of people, taking all local circumstances into consideration.

### **Industry in Relation to Leprosy**

30. Here again the problem can be dealt with satisfactorily only by taking local circumstances into account. In the first place provincial leprosy organisations should attempt to estimate the extent of incidence of leprosy among industrial workers in the different industrial centres included in their territories. Next, wherever it is shown to be prevalent, measures for the detection, isolation and treatment of all infective cases should be undertaken. It is essential to ensure that such infective patients are not permitted to live along with other workers in quarters, which are often overcrowded. If a local organisation to deal with leprosy in the general population has been developed, the facilities which are available there can of course be utilised for industrial workers also. If such facilities do not exist, special provision will have to be made if the prevalence of leprosy among industrial workers is sufficiently high to justify it. If not, the few cases to be dealt with can perhaps be best provided for by transferring them to the nearest group isolation colony.

### **Legislation**

31. The Special Committee has discussed in its report (extracts from the report are given in Appendix 19) the defects of existing legislation regarding leprosy in British India and has pointed out the need for providing a comprehensive Act, which will modernise the existing law and deal with the problem in the country as a whole. It has also indicated certain principles on which such legislation should be based. We recommend that the suggestions of the Committee should receive the early attention of Governments in the country.

## **7. VENEREAL DISEASES**

### **Introduction**

1. The incidence of venereal diseases in India is unknown. In our review of the venereal diseases problem in the previous volume of the report, we have already referred to a survey made by Sir John Megaw, a former Director-General of the Indian Medical Service, of the incidence of syphilis and gonorrhoea in this country. For reasons already indicated there, the value of an estimate based on this survey must be considered to be strictly limited. Nevertheless, the rate of total incidence for these two diseases which he calculated, namely, 37 per thousand of the population, is sufficiently high to point to the urgent need for fuller investigation as well as for the starting of a campaign against them on as extensive a scale as circumstances would permit. Their importance from the point of view of producing sickness and incapacitation cannot be over-emphasized. Both syphilis and gonorrhoea are responsible for much blindness. Of the two, syphilis is the more important. If not treated in time

and adequately it produces degenerative changes of a varied character in the internal organs of the body and, in a certain number of cases, it also causes the condition known as the general paralysis of the insane. The disease is transmissible from parent to offspring and is responsible for a considerable proportion of the abortions and premature births that take place. Syphilis accounts also for a large amount of mental deficiency. Gonorrhoea, in its turn, contributes to ill-health through joint troubles and various conditions affecting the genito-urinary organs in both sexes. In women it may produce sterility.

2. Gonorrhoea and syphilis are infectious diseases and the main lines on which action should be taken against them would therefore seem to be the same as those adopted against other communicable diseases, namely, (a) notification of their occurrence and (b) control of the spread of infection from persons who are in an infective stage to those who are healthy. There are, however, certain special features in respect of these two diseases which would necessitate a modification of the normal procedure adopted for the control of other infections. These arise from two causes. Firstly, the social stigma associated with venereal diseases results in the desire for concealment on the part of those who suffer from them. Secondly, as their spread is mainly through sexual intercourse, the measures for control must differ, to some extent at least, from those adopted to prevent the transmission of such diseases as malaria, smallpox, cholera or tuberculosis.

### Notification

3. While compulsory notification has been recognised as a measure of great importance in dealing with infectious diseases in general, such a measure would probably fail to achieve the purpose in view when applied in the case of venereal diseases because of the widely prevalent desire, on the part of the patients and their relatives, to conceal their occurrence. The British Parliament, when sanctioning for the first time in 1916 a comprehensive scheme for a campaign against these diseases, took this view and did not include compulsory notification as one of the measures to be adopted by health authorities. It was held that, by the provision of adequate facilities for free and confidential treatment, sufficient response could be evoked from the people to make the fight against these diseases effective. This assumption has in the main been fulfilled. Between 1917, when the first free clinics were opened, and 1940 the number of such treatment centres in England and Wales rose to 188. It is true that, in the absence of the enforcement of compulsory notification, the numbers of cases treated in these clinics can provide only an estimate of the probable incidence of the infections in the population. It seems however fairly safe to assume that, with the continuous education of the people in regard to the dangers associated with these diseases, the annual numbers treated for newly acquired infection should increasingly become reasonably correct indices of the prevalence of syphilis and gonorrhoea. Judged by such figures their incidence decreased by about 70 per cent. between 1917 and 1940. Additional evidence of a confirmatory nature is a reduction in the mortality due to congenital syphilis to the extent of about 62 per cent. during the same period. It is understood, on the other hand, that in Denmark, Holland, Norway and Sweden

notification and treatment are both compulsory and that the incidence of syphilis has in consequence been very considerably reduced. It is argued that, in order to ensure complete treatment so as to render the patient non-infective, and to extend such treatment to as wide a circle of patients as possible, the element of compulsion is essential. This may be so. We feel, however, that the introduction of compulsory measures represents a stage, which can be reached only after a period of persuasive propaganda and the provision of adequate free treatment facilities have awakened in the public mind a recognition of the supreme importance of stamping out venereal diseases and have created a demand for the enforcement of the strictest possible measures of control. In these circumstances we believe that, in organising a campaign against these diseases in India, it is not desirable to introduce compulsory notification at this stage.

### **The Organisation of Control Measures**

4. The measures which are necessary for the control of these diseases may be divided into two broad groups, namely, (1) those which provide the best available forms of medical care, preventive and curative, and (2) those which are designed to discourage promiscuity and to control prostitution.

### **Provision of Medical Care, Preventive and Curative**

5. The measures required under this head include:—

- (1) free treatment to all persons seeking such treatment;
- (2) facilities, without payment of fees, for personal prophylaxis;
- (3) adequate diagnostic facilities;
- (4) the creation and maintenance of a follow-up service and
- (5) education of the people in regard to the spread and control of these diseases.

The sequence in which these measures are set out is not meant to suggest any priority in regard to their implementation. The aim should, indeed, be to promote as far as possible their simultaneous development. For instance, the provision of facilities for free treatment and personal prophylaxis is likely to be of little value unless an intensive educational effort organised at the same time helps to promote a desire in the people to avail themselves of such facilities. The establishment of adequate laboratory services to ensure the correct diagnosis of these diseases is essential for the organisation of the campaign on sound lines. The proposed follow-up service is intended to carry into the homes of the people the preventive care which forms a fundamental part of the fight against these diseases, and should therefore be established from the very beginning.

6. It seems to us that a special organisation for dealing with venereal diseases should be established in each province as a part of the provincial health department. The creation of the post of a Provincial Venereal Diseases Officer, with suitable assistants, on the establishment of each Provincial Director of Health Services is necessary. It should be the duty of this officer to plan the campaign against these diseases and to promote the development of the required services in close collaboration with the other branches of health administration. Certain suggestions for the composition of this organisation at the provincial headquarters are given in Appendix 8.



These will of course be subject to such variations as the requirements of individual provinces may necessitate. For the provision of free treatment and of facilities for personal prophylaxis we recommend that the following provision should be made during the short-term programme:—

(1) The establishment of venereal diseases clinics in association with the main general hospitals at the headquarters of the province, of each district and of every secondary health unit. We suggest that, in addition, such treatment facilities should be extended to each of the 80-bed hospitals we have recommended for a group of primary units and to the dispensary attached to each primary health centre, as soon as circumstances permit. A word about personal prophylaxis seems desirable. An individual, who has already been exposed to these infections, can be protected against them within the first few hours after such exposure, by certain relatively simple prophylactic measures. At each of the centres of treatment we suggest that facilities for personal prophylaxis should also be made available.

#### **Diagnostic Facilities**

(2) Diagnostic facilities should be provided in the public health laboratory at the provincial headquarters and in the regional laboratories, the establishment of which we have recommended in the section dealing with medical research. In view of the importance of helping the fight against these diseases to the greatest possible extent, we recommend that such facilities should be made available, free of charge, not only to public institutions dealing with these diseases but also to all private practitioners.

#### **Special Training for Doctors**

7. The number of doctors who have had special training in the diagnosis and treatment of venereal diseases is, at present, extremely limited. The proposed expansion of treatment facilities will be possible only with the production of a sufficient number of doctors with such specialised training. At the headquarters of a number of provinces venereal diseases clinics have been functioning for some time. In some of these provinces such clinics exist in association with a certain number of the larger district headquarters hospitals also. The clinics at the provincial headquarters and such of the clinics in the districts as may be considered suitable should be organised, as soon as possible, to give special training in these diseases. Such training should be made available not only to doctors in public service but also to private practitioners.

#### **The Creation and Maintenance of a Follow-up Service**

8. Here, as in the case of tuberculosis, a follow-up service to establish contact with the homes of the patients is of great importance. Such a service can considerably help the campaign partly by encouraging patients to carry out the preventive measures they have been advised to adopt and partly by securing, through persuasion, the examination, at the special clinics for venereal diseases, of the contacts of such patients and their treatment, where necessary. The public health nurse will have to undertake the duties in connection with the home visiting programme, in addition to the functions she will perform in other fields of health activity. In the larger cities, where the incidence of these diseases may be definitely higher than in the country as a whole, it may be necessary to employ special workers to undertake

home visiting. It is believed that this duty can, with advantage, be combined with rehabilitation work to which we shall refer later. For this widened sphere of activity it seems desirable to employ a hospital social worker in the place of the public health nurse. We have indicated, in the chapter dealing with professional education, the nature of the training the social worker will receive and of the duties she may be expected to perform.

### **Two other Measures**

9. Two other measures which have been found to be useful in England in the campaign against venereal diseases may also be considered here. These are the prohibition of treatment of these diseases by all except those who possess a registerable medical qualification and the restriction of advertisements regarding specific remedies and other forms of treatment. The purpose in view is to ensure that the patients concerned should receive the best forms of treatment which the latest developments in medical science can make available to them and to exclude quacks and their spurious remedies from the field altogether. The imposition of these restrictions on the treatment of venereal diseases has its justification in the fact that, in the campaign against them, the quack and his methods of treatment are likely to play an even more disastrous part than in the case of other diseases. We therefore think that only persons holding registerable qualifications should be permitted to treat venereal diseases in India also and that no advertisements regarding drugs or forms of treatment for these diseases should be permitted, except those which are approved by the Provincial Ministry of Health. A minute relating to this by one of us (Mr. N. M. Joshi) is appended at the end of this section.

### **Measures designed to discourage Promiscuity and to control Prostitution**

10. Measures designed to discourage promiscuity in the community and to control prostitution are obviously more difficult to devise and enforce than the medical measures we have recommended in the preceding paragraphs. Education in a wide sense of the term, so as to promote the growth of the individual's moral sense and of his responsibility towards himself and the community, and sex education intended to create a correct appreciation of the problems of sex relationship and to impart knowledge regarding the spread of venereal diseases and the dangers that arise from them, must together provide the conditions essential to secure the success of any attempt to control indiscriminate sexual intercourse, whether it be in the restricted field of prostitution or outside it. The formulation of proposals to deal with education in its wider aspect falls clearly beyond the scope of this report. Even in respect of the more limited sphere of sex education we propose to make only a few remarks. The consensus of informed opinion seems to be that such education should start in early childhood and that the fundamental facts relating to sex should be given to children without the emotional colour with which persons at older ages are likely to envelop the subject. On this background of factual knowledge, it will be possible to build a superstructure of moral and ethical ideas in regard to sex relationship in the developing mind of the adolescent boy and girl. Both parents and teachers should, therefore, be in a position to give sex education

to children. The need for their collaboration in the task becomes emphasised when it is remembered that, at the adolescent stage, the reaction of the boy or girl towards sex education will largely be influenced by the background of discipline and culture which the home and school environments have already provided for the individual. We see, therefore, no short cut to the attainment of a desirable standard of universal sex education in the country. A beginning should be made by providing such instruction to teachers in training schools and colleges and, through them, to school children and college students. The sex education of adults can perhaps be attempted as a part of the programme of adult education. The successive stages of the postwar scheme of general education should, as it proceeds, be able to lay increasing emphasis on sex education also, the content and quality of the instruction given to different sections of the student population being varied according to the age and general receptive level attained by these sections.

### Prostitution

11. Prostitution plays an important part in the spread of venereal diseases. A prostitute seldom escapes infection and she generally communicates it to a certain number of men who, in their turn, may infect other women including their own wives if they are married. Control of prostitution is therefore a most important measure in the campaign against venereal diseases.

12. Prostitution constitutes in itself one of the major social evils in all countries. Its underlying causes are complex and it is not easy to deal with them. Prostitution flourishes most in the larger urban centres. In the fight against it we consider it important to direct the attack on those, male or female, who are responsible for the maintenance of brothels and for the exploitation of the unfortunate prostitute as well as on the victims of such exploitation. We gather that, in many of the larger towns and cities, establishments under such appellations as "Turkish baths" or "massage institutions" are in existence, many of which are really houses for prostitution. We understand that an adequate definition of the term "brothel" is necessary in order to facilitate the enforcement of the law against such institutions and their keepers. Such a definition should be comprehensive enough to include establishments which, under other names, seek to serve the same purpose. Severe penalties should be prescribed for the keepers of such institutions and an attempt should be made to deal severely, under the law, with the landlords who permit the use of their premises for this purpose.

13. As regards the prostitute, provision should be made, where required, for appropriate medical treatment until she is cured or at least rendered non-infective. Measures for her re-education and return to the normal mode of life are equally necessary. In a large proportion of cases girls are lured into this unfortunate way of life partly as the result of poverty and partly due to the temptations to which they are exposed by their exploiters. A rehabilitation programme will have to provide not only for their general education, as in many cases they may be illiterate, but also for moral and vocational training so that they may be able to turn over to a new mode of life. The possibility of establishing rescue homes and rehabilitation houses in the larger cities requires serious consideration. While both types of institutions should play their part in the rehabilitation campaign, they

do not serve the same purpose. The rescue home is meant to provide, as its name implies, a temporary shelter to those who are removed from the prostitution houses. The provision of such homes seems to be essential if brothels are to be suppressed by the enforcement of the law, partly for humanitarian reasons and partly to protect the public against the effects of letting loose the unfortunate inmates of these brothels. In the rescue home provision should be made for a detailed medical examination of the women admitted, in order to determine whether they are suffering from venereal diseases or not. Those who are, should be persuaded to go into the rehabilitation house which we shall describe presently. The function of the rescue home should be mainly educative, while its atmosphere should be one of sympathy and of moral suasion. The relatively younger women, who have not yet become hardened prostitutes are the persons who are likely to be benefitted by the ministrations available at the rescue home. Those who have acquired venereal diseases will require prolonged stay and treatment and it is therefore better for them to be removed to a separate institution, the rehabilitation house. Many of the women requiring such treatment are also likely to have been long inured to a life of prostitution. We are suggesting a separation of these two classes among the unfortunate victims of this social vice because we believe that, even from the point of view of re-education and of return to normal life, such separation will be of advantage to the less hardened type of prostitute.

14. The rehabilitation house should provide the best medical aid that can be given for the treatment of the diseases. It seems therefore desirable that the rehabilitation house should be developed in association with a well conducted venereal diseases clinic. Such association has also the advantage that, in addition to the provision of medical aid, the social workers attached to the clinic will be able to help in the rehabilitation campaign.

15. In the early stages of our programme against venereal diseases, admission to these institutions will have to be on a voluntary basis. Religious and other organisations interested in social welfare can find here a fruitful field of activity in persuading such women to enter the rehabilitation house and remain there sufficiently long to be benefitted by the medical care and other forms of service they will render. The social workers attached to the clinic can also assist in this work.

16. We would, however, emphasise that, both in the rescue home and in the rehabilitation house, the atmosphere should not be such as to make these women feel that they are objects either of pity or of constant moral supervision for reclamation to normal life. Such an attitude on the part of the management of these institutions is likely to antagonise them to the efforts made to improve them. What is required is that their confidence should be won and there is perhaps no better way of disarming their fears and suspicions than by according them the same consideration and treatment as are given to women in ordinary life. The prostitute is usually treated with little civility by the general public and her reaction to such behaviour is naturally one of hostility. She will, therefore, respond more readily to an attitude which places her on a plane of equality with her sister in ordinary social life. Side by side with such treatment there should be ample provision for educational work and recreational

facilities as all these will enable the women to turn their back on the past and to begin a new life.

17. While efforts for the education and rehabilitation of the prostitute must have a prominent place in the campaign against these diseases, a raising of the economic status of women in general and the provision of opportunities, on as large a scale as possible, for their vocational training and subsequent employment will be equally necessary if the root causes of this social evil are to be adequately controlled. Even with such measures there will remain a certain number of unfortunate women, who are psychopaths and feeble-minded persons and are, therefore, unable to learn and practise any useful form of employment and probably prefer to continue making their living through prostitution. This small class will require more prolonged stay and education in the rehabilitation institutions we have recommended. A certain proportion of them may, through sympathetic handling and cultural training, become re-educated into the normal mode of life.

#### Minute by Mr. N. M. Joshi

Mr. Joshi holds that application of legislation providing treatment of venereal diseases by any one except those who hold registrable qualifications, should be enforced in provinces and areas only when a sufficient number of persons holding registrable qualifications are available within a reasonable distance from the residence of patients.

### 8. HOOKWORM DISEASE

1. In the volume dealing with our survey of health conditions in India we have already indicated the mode of spread of hookworm and have described briefly the results following a heavy infestation of man's intestine by this worm. It produces its harmful effects on the human host by the loss of blood it causes through feeding on him, by the state of irritation of the bowels which it produces and the resulting disturbance of the digestive function and by the secretion of a poisonous substance which prevents clotting and thus promotes bleeding. The devitalisation it causes to the person concerned helps to make the chance of other infections being taken up, *e.g.*, tuberculosis, much greater. Among certain groups of the population of many countries hookworm infestation is practically universal and the intensity of such infestation in individuals is high. Such groups are generally backward in respect of social progress and, as pointed out in the 1917 report of the International Health Board of the Rockefeller Foundation, the cumulative effects of the disease on them—physical, economic, intellectual and moral—may go far towards explaining the retardation of their progress.

2. The disease is widely prevalent in India. The labour populations of plantations in Assam and South India are heavily affected as well as the general population of certain parts of Travancore, Malabar and South Kanara. Varying intensities of infestation are found in the provinces of Bengal, Bihar, Orissa, the eastern portion of the Central Provinces, some parts of the United Provinces and the Punjab and on the east coast of Madras. The North-West Frontier Province, Rajputana, Sind, Kathiawar, Central India States, Hyderabad (Deccan) and Mysore State are practically free.

3. The proposals we have set forth in this report for ensuring adequate provision for nightsoil conservancy in rural and urban areas will, if implemented, constitute an important step in the control of hookworm disease. Soil pollution through human excreta and the habit of walking barefoot constitute the two main factors involved in the spread of the disease. What is therefore needed is that people should be taught how to render these factors inoperative. The health education campaign, which we hope will be conducted in the schools and colleges and among the general population as an essential part of our programme, should help materially towards this end. As a long-term measure we feel that the development of our health programme will suffice to solve the problem of hookworm disease. In the meantime, as heavy infestation exists in certain groups of people, it seems necessary to institute prompt and energetic measures among these groups. Mass treatment by the administration of the appropriate drugs, the early development of a system of nightsoil conservancy on lines suited to meet local conditions and education of the people in the modes of spread of this disease and in the measures to be adopted against it should be carried out on as large a scale as possible in the areas concerned.

### 9. FILARIASIS

1. Filariasis is widely prevalent in certain parts of India where a hot and humid climate favours the breeding of the special types of mosquitoes, which are responsible for its transmission. The disease leads to the permanent swelling of the legs and of certain other parts of the body besides causing recurring attacks of fever and inflammation of the lymphatic system. Although it does not cause death, it is responsible for a considerable amount of preventable suffering and disability.

2. Bengal is the most heavily affected province in India. The incidence of filariasis is high in the western districts of this province and its intensity gradually decreases eastwards and northwards. The Chittagong Hill Tracts and the northern districts of Jalpaiguri and Darjeeling are free. In Assam the disease is present in many districts although its intensity is lower than in Bengal. In Bihar its incidence is relatively high in the Gangetic plain and in Orissa in the coastal districts. In Madras areas of moderate prevalence exist in the districts of Tanjore, Kistna, Godavari and Vizagapatam and in Saidapet near Madras City, while the coastal tracts of Malabar and South Kanara districts and of the Indian States of Travancore and Cochin show areas of high incidence.

3. Filariasis affects the health and wellbeing of large numbers of persons living in endemic areas. Extended research has failed to produce a satisfactory cure for this disease. In view of the remarkable results that modern scientific developments have been able to achieve in the treatment of various diseases, there is every reason to hope that a cure will be found for filariasis, which has remained so far a challenge to workers in tropical medicine. The only effective measures against the disease known at present are those which are concerned with the control of the carrier species of mosquito. The organisation we have recommended for anti-mosquito measures in the section dealing with malaria should direct its attention, in the endemic centres of filariasis, to the carriers of this disease also and should attempt to secure an effective reduction in the types of mosquitoes.

## 10. GUINEA-WORM DISEASE

1. Guinea-worm disease is widely prevalent in certain districts of the N.-W. F. Province while its incidence is relatively low in the Punjab. The Rajputana desert is free but many of the States in Rajputana and Central India contain heavily infected areas. In the Central Provinces, Bombay Presidency, Nizam's Dominions and Madras Presidency the disease is prevalent over wide areas. Well watered tracts, with a fairly heavy rainfall such as Bengal, are generally free.

2. The prevalence of the disease is dependent on opportunities for the infection of water supplies by persons harbouring the worm. In the affected areas step wells, tanks and other sources of water liable to contamination are responsible for keeping up the infection. For the destruction of cyclops, which harbour the embryos of the worm, the application of adequate quantities of lime to such water supplies has been shown to be effective. Even straining the water through fine muslin will suffice to remove the cyclops and render the water innocuous. But, from the point of view of permanent relief, it is essential to protect step wells, tanks and other open sources of water supply from contamination by persons harbouring the worm. Our programme for giving safe water supplies to towns and villages will provide this permanent protection in due course. In the meantime it is essential that the public health staff should, in the areas in which the disease is endemic, try their utmost to get existing step wells converted into draw wells and to make safe other supplies, which cannot be so converted, by the regular application of lime and by instructing the people in the ways in which reinfection can be prevented.

## 11. CANCER

1. In our review of the cancer problem in India in the previous volume of this report, we have pointed out that the view held in many quarters that cancer is rare in India is not correct. Such evidence as is available seems to suggest that its relative incidence in India is probably as high as in western countries, taking into consideration the fact that the disease generally occurs at the higher ages of life and that a large proportion of the population of this country must be at the younger ages as compared with the inhabitants of those countries, in view of the average length of life here being much shorter than in the west.

2. Our proposals for the short term programme are:—

(1) Provision for radium and for deep X-ray treatments should be made, in addition to existing centres for such treatments, at all the hospitals associated with the present medical colleges and with those which will be established during the short-term programme. The centres at which such facilities are now available are shown in Appendix 20.

(2) In addition to the Tata Memorial Cancer Research Hospital at Bombay, three more institutions for promoting advanced research and teaching in the subject are needed to serve north-western, eastern and southern India respectively. The collective efforts of these institutes, when established, should help to throw considerable light on the incidence and relative distribution of the different types of malignant disease in India. These institutes would also serve as

centres for the training of those who will be responsible for developing cancer research and teaching in the medical colleges of the country.

If the experience of western countries regarding the trends of morbidity and mortality due to cancer are any indication of similar trends in India, the problem of the prevention and cure of this disease must have an important place in our national health programme. It is therefore hoped that cancer research will attract to itself the most gifted among the medical research workers that the country produces.

(3) A considerable extension of diagnostic facilities will be necessary. The laboratories attached to the hospitals at the secondary health centres and to the teaching hospitals, the provincial public health laboratory organisation with its regional branches, which we have recommended in the chapter on medical research and the special institutes referred to above should all help to provide this extended service.

(4) One of us (Dr. Vishwanath) and Dr. Khem Singh Greval, as the result of an extended study of biopsy and autopsy material relating to cancer available in the records of the hospitals attached to the teaching medical institutions in the country, came to the conclusion that, "whether it was the cervix, the oral cavity, the penis, the skin or the gastro-intestinal tract, the factor of irritation seems to excel all other possible causes and brings the problem of this fell disease within the scope of preventive medicine." It is therefore essential to develop an educational campaign in regard to the removal, as far as possible, of the causes of such irritation. This campaign should include, within its scope, both the general public and the medical profession. The people should be instructed to recognise certain early indications which might suggest the presence of cancer and to seek medical advice without delay, in order to ensure adequate examination and treatment, where necessary. The medical profession should be made more cancer-minded and should be trained to recognise early signs of the disease in the patient. It will be the duty of the Health Departments in the country to provide for such education as an essential part of the campaign against cancer.

## 12. MENTAL DISEASES AND MENTAL DEFICIENCY

### Introduction

1. The physical and mental health of an individual are inter-related and no health programme can be considered complete without adequate provision for the treatment of mental ill-health and for the promotion of positive mental health. Positive mental health is characterised by discriminative self-restraint associated with consideration for others. A man in such positive health uses effectively his intelligence and talents to obtain the maximum satisfaction from life, with the minimum of discomfort to others. He will not allow himself to be overwhelmed by the stresses and strains inseparable from ordinary existence. He not only profits from experience but, under favourable circumstances, can transcend such experience. It should be the aim of every health programme to include measures meant to assist the individual to achieve mental stability and poise and develop into a useful citizen.



2. Conditions of mental ill-health may be divided into two broad groups, (i) mental disorder and (ii) mental deficiency.

Mental disorder may be either inherited or acquired, and very often it is both. No age is exempt from mental disorder although the types may be different at different age periods. A large proportion of them is amenable to modern methods of treatment.

Mental deficiency is ascribed, on the other hand, to a hereditary or congenital taint or to some accident or illness occurring just before or soon after birth. There are grades of mental deficiency, and although the condition is generally regarded as incurable, yet by proper care and supervision, the majority of defectives can be made to lead useful, but segregated lives; and what is more important from the point of view of society, they can be prevented from becoming criminals and in the case of girls, social menaces.

3. It may be of advantage, at this stage, to examine such evidence as is available regarding the incidence of these conditions elsewhere and attempt to draw from it inferences applicable to this country.

In England and Wales there were at the beginning of 1937 about 129,750 patients under treatment in the mental hospitals maintained by the various local authorities, who are responsible, under the law, for making such provision. This figure gives a proportion of about 3.2 mental patients per 1,000 of the population.

In America, the annual admission rate is more than 170,000, to the public mental hospitals, in which is already resident a population of half a million patients. More hospital beds are devoted to the care of the mentally sick than to the treatment of all other patients combined. In some States, as much as one-eighth of the revenue is earmarked for expenditure on the mentally sick. There are 500,000 mental defectives, and perhaps as many epileptics. Amongst criminals, there is a very large number whose offences are attributable to diseases and defects of the mind and maladjusted personalities.

During the World War, one-sixth of all casualties were neuropsychiatric, excluding wounds, and a peak load of one-third or more was sometimes reached by such causes. At least one child out of every twenty-seven children born in America and one in thirty born in England is likely to become, in the course of a few years, mentally sick to such an extent as to require admission in public hospitals. This is an appalling figure, but it does not include large groups of persons in whom the essential basis of ill-health is either a defective personality or an inability to adjust themselves to a difficult environment, while they are diagnosed as cases of debility, gastritis, anaemia or rheumatism.

4. While some of the mental disorders are directly due to infections, or are associated with chemical or structural changes in the body, in most of the others however, no such changes can be discovered. They are termed functional and include two of the largest groups of mental disorder, the more severe forms being known as psychoses and the less severe forms as psycho-neuroses.

Schizophrenia (split mind) and affective reactions (mania and melancholia) collectively termed bio-genetic psychoses, account for

at least fifty per cent. of the admissions to mental hospitals and for at least a third of the permanent, incurable, population of these public institutions.

5. Psycho-neuroses include a variety of forms of mental ill-health, hysterias, phobias, anxiety states, obsessional and compulsive neuroses belong to this group as well as problem children, stammerers, certain classes of delinquents and most of those who used to be diagnosed as suffering from shell shock. Psycho-neurosis also accounts for chronic ill-health in many men and women and for many so called nervous break-downs. The psycho-neurotic condition is often of a mild nature and most persons suffering from it do not find their way into hospitals. Psycho-neurosis is the most important single cause for absenteeism in industry, for unemployment and for poor turn-over in factories. Dr. Halliday the Glasgow Regional Medical Officer of the Department of Health for Scotland under the Insurance Act, discovered that out of 1,000 consecutive cases kept away from work for 12 weeks or more, 38.5 per cent. were in what was primarily a psycho-neurotic condition. He showed that the majority of these were certified as suffering from organic diseases including gastritis, debility, anaemia and rheumatism. He estimated that the incidence of psycho-neurosis among the employed males was 28 per cent., while it was 87 per cent. among the unemployed. Further, he showed that in one inquiry of 145 consecutive cases described as rheumatic 39.8 per cent., and in another 62 consecutive cases 37 per cent. were psycho-neurotic. In a close investigation of the psycho-neuroses of 21 insured persons he established a definite connection between neurosis and rheumatism. Dr. Thomas M. Ling, the Medical Officer of Joseph Lucas Ltd., Birmingham, analysed the case records of 200 consecutive cases of sick employees. He concluded that 27 per cent., who were absent for two or more weeks, were suffering from psycho-neurosis, while the period during which another 32 per cent. stayed away from work was prolonged by psycho-neurosis. A series of articles in the first three numbers of Vol. X of the Human Factor, the organ of the National Institute of Industrial Psychology, by Dr. Garland, provides evidence of a similar character obtained from a factory employing between 2,000 and 3,000 girls. Sir Maurice Cassidy, a consulting cardiologist, has also attributed 29.15 per cent. of the cases coming to him to psycho-neurotic causes. It is suspected too, that accident proneness is due to some form of psychological condition. The Industrial Health Research Board, for example, have discovered that 75 per cent. of the factory accidents generally occur among 25 per cent. of the employees. Thus there are evidently many people suffering from mental ill-health which is never diagnosed. Their health and their work often suffer and sometimes they may be even dangerous to their fellow citizens, particularly if they handle dangerous machinery, or drive cars.\* It is clear that the number of persons suffering from mental disorders of varying degrees of intensity must be much more than those who are admitted and treated in the mental hospitals in England.

6. As regards mental deficiency the Joint Committee of the Board of Education and the Board of Control on Mental Deficiency (commonly known as the Wood Committee) gave in its report,

\* "Report on the British Health Services", PEP (Political and Economic Planning), pages 352-353.

which was issued in 1929, an estimate of about 300,000 mental defectives in England and Wales or 8 per 1,000 of the population.

7. It will be seen that varying degrees of mental ill-health and mental instability affect a much larger section of the community than that which the statistics for mental patients suggest. General medical consultants in large cities in America have found not only that forty to fifty per cent. of their consultations concern psycho-neurotic conditions, wherein no organic pathology can be found, but also that purely psychiatric or emotional factors are estimated to cause fifty to sixty per cent. of physical illness. Asthma, eczema, gastric ulcer, high blood pressure are a few examples. Hence has sprung a new branch of medicine—psycho-somatic medicine. The expenditure on mental hospitals in America is a billion dollars. It has been estimated that, if the time each patient stayed in hospital could be reduced by attention to the emotional factors in physical illness, the annual saving in public expenditure would be several million dollars.

### **The Result of Treatment**

8. In connection with the general impression that the results of treatment in mental diseases are disappointing, Strecker and Ebaugh (1940) point out that "It is conservatively estimated that between 60 and 75 per cent. of the psychoses which are comparable to what a general physician would designate 'acute' are recoverable. Particularly in psychiatry do we meet conditions and situations which are capable of considerable modification in a favourable direction even though a complete cure may not be effected. This is particularly true in incipient and early Schizophrenia, and the failure to recognise this potentiality has made the outlook seem even gloomier than it really is."

In recent years, an increasing number of articles reporting a high proportion of cures, social remissions, and improvements in incurable patients have appeared. Recent progress in the understanding and treatment of mental disorder has been so spectacular that the chances of recovery of a mental patient can be said to be greater than those of a patient suffering from any other illness. The therapies deserving mention are shock therapy by cardiazol, and insulin, continuous narcosis, and exploratory therapy by a sodium pentothal, surgical approach to the brain by sectioning the white matter (leucotomy), and the use of penicillin, hormones, vitamins, and direct and indirect psycho-therapy.

### **The present position in India**

9. The position in India is extremely unsatisfactory. It has been mentioned above that in England, in 1937, the ratio of mental patients treated in hospitals was 3.2 per 1,000 of the population, and in America, the rate has varied from 5 to 8 per 1,000 in different years and in different States. These figures give only a rough indication of the extent of prevalence of mental disorder in the two countries. In India there is no reason to believe that the rate of incidence of mental disorder is in any way less than those in England and the United States. While it is true that, in this country, the higher rate of infant mortality and the shorter span of life for the individual should help to produce a smaller proportion of persons liable to adolescent and senile psychoses respectively, there are other factors influencing the development of mental disorder which are operative here to a greater extent than in those two

countries. Chronic starvation or under-nutrition, tropical fevers, anaemias and frequent childbirth in women who are unfit for motherhood are responsible for large numbers of mental breakdown in this country. On the other hand, purely sociological causes may not be operative in India to the same extent as in the other two countries.

In view of these considerations, even if the proportion of mental patients in India be taken as 2 per 1,000 of the population, hospital accommodation should be available for at least 800,000 mental patients. On the other hand there are only a little over ten thousand beds for such patients. The great disparity in respect of mental hospital accommodation between England and India can be shown in another way. In India the existing number of mental hospital beds is in the ratio of one bed to about 40,000 of the population (taking the present population of the country as 400 millions) while, in England, the corresponding ratio is approximately one bed to 300 of the population. Thus the provision in India for the institutional care of insane persons is about 130 times less than that existing in England, even if we estimate the rate of incidence of such cases here as about 37·5 per cent. less than the rate in that country. As regards the possible numbers of persons suffering from varying degrees of mental disorder, who may not require hospitalisation and yet should receive treatment, and of those suffering from mental deficiency, we have no information at all. It seems, however, almost certain that their numbers are likely to run into some millions in this country, if the ratio of incidence in England or America can be taken as even an approximate guide for estimating the numbers of such cases in India. Psychological and medical treatment are necessary for many forms of psycho-neuroses. Mental deficiency will require provision on a wide scale, including special educational facilities and institutional care for children suffering from various forms of this condition and segregation and treatment in institutions for a considerable proportion of mentally deficient adults also. Provision for these two classes of sufferers from mental diseases is almost non-existent in India.

In the previous volume of the report dealing with a review of health conditions in India we have already referred to the extremely unsatisfactory conditions of some of the existing mental hospitals which, it will be seen, are altogether too few to meet the requirements of the country. Colonel M. Taylor, I.M.S., Medical Superintendent, Ranchi European Mental Hospital, who visited, at our request, all the major mental hospitals in the country and prepared a report (Appendix 21) for us, says "every mental hospital which I have visited is disgracefully under-staffed. They have scarcely enough professional workers to give more than cursory attention to the patients." He also states that "Seven of the largest mental hospitals in India have men appointed as superintendents at salaries that a first class mechanic in Tata Works would scorn, six of them have little or no postgraduate experience or training in psychological medicine, and yet these men have been charged with the supervision of large hospitals, and what is more important, human lives. The Deputy Superintendents and subordinate medical staff are utterly untrained in psychiatry." The nursing staff and the ward attendants attached to most of these hospitals are, he points out, insufficiently trained and

inadequate in numbers to do efficient service. The use of social workers and the provision of occupational and recreational therapy, which constitute important parts of a modern mental health programme, have, speaking generally, received quite insufficient attention in this country.

### OUR PROPOSALS

10. In putting forward the following proposals we have had the benefit of advice from a small sub-committee, which we appointed, consisting of mental specialists from different parts of India and from Colonel M. Taylor, to whose report we have already referred. In our view the most important step to be taken is the formulation of a mental health programme for the country after a preliminary investigation of the needs of individual provinces. Such a programme should aim at providing for the community, in successive stages, a modern mental health service embracing both its preventive and curative aspects. As a part of the implementation of such a programme two of the most urgent needs that should be met are (1) an improvement and augmentation of existing institutional facilities for the treatment of mental ill-health and (2) provision for the training of different types of mental health workers, including doctors and ancillary personnel. With these objects in view we make the following recommendations for the short-term programme:—

- (a) the creation of mental health organisations as part of the establishments under the Director General of Health Services at the Centre and of the Provincial Directors of Health Services;
- (b) the improvement of the existing 17 mental hospitals in British India and the establishment of two new institutions during the first five years and of five more during the next five years;
- (c) the provision of facilities for training in mental health for medical men in India and abroad and for ancillary personnel in India and
- (d) the establishment of a Department of Mental Health in the proposed All-India Medical Institute.

#### **(a) The Creation of Mental Health Organisations as part of the Directorate of Health, Central and Provincial.**

11. The creation of mental health organisations as part of the establishments of the Director General of Health Services and of the Provincial Directors of Health Services is, in our view, of such great importance that we have placed it first among our recommendations. The problems of mental health have so far received very little attention in India and we believe that the appointment of officers with a wide experience of modern developments in this field at the Centre and in the Provinces is essential for the carrying out of preliminary investigations, the formulation of a sound programme of action and its effective implementation. So little information is available regarding the incidence of mental ill-health in the country and the developments in this field of health administration, even in the more progressive countries, are so recent that we feel we shall not be justified in attempting to make detailed recommendations regarding the mental health organisation which the country requires. We must leave this task to the Health Departments with the guidance of the specialists, whose appointment we have suggested.

12. We realise that, with the existing lack of medical men with special training in this subject in India, the appointment of separate mental specialists on the staff of the Director General of Health Services and of every Provincial Director may not be easy. We would suggest that a highly qualified person, with wide experience of the different branches of mental health work, should be appointed on the staff of the Central Directorate of Health and that his advice should be made available to the provinces in the development of their programmes. Until officers with similar qualifications become available for appointment in the provinces, we put forward certain suggestions for an interim arrangement. In a number of provinces mental hospitals exist at their headquarters. Bombay and Bengal are two notable exceptions among the major provinces. We are, however, suggesting the establishment of a 200-bed mental hospital at Bombay and at Calcutta with the least practicable delay. As has already been pointed out, in most of the existing mental hospitals the superintendents are medical men without any special training in psychological medicine. We would suggest that steps should be taken, without delay, to appoint to these institutions (including the proposed new hospitals at Bombay and Calcutta) fully qualified mental specialists who can perform the dual function of being the superintendent of the mental hospital at the provincial headquarters and of acting as the adviser to the Director of Health Services on mental health administration. We suggest this arrangement only until qualified mental specialists become available in sufficient numbers to permit the appointment of separate whole-time officials on the provincial Directorates of Health. We believe that the duties in connection with the development of mental health work in a province require the attention of a full time officer.

**(b) An improvement of Institutional Facilities for the Treatment of Mental Ill-health**

13. The existing mental hospitals, with the accommodation available in each, and the places where they are located are shown in Appendix 22. We were advised by the special Sub-committee that three types of institutions are required for the treatment of mental patients, *viz.*, (i) hospitals for general mental patients, (ii) homes for mental deficient and (iii) homes for incurables and for senile cases. It has further suggested that, normally, the accommodation provided in an institution of each of these types should be 1,000 beds. The staff required and the estimates of cost for each type of institution have been worked out for us by the Sub-committee and they are given as Appendix 23. The capital outlay required on each of these types of institutions is estimated at Rs. 10 lakhs. The annual recurring expenditure per bed is likely to be Rs. 1,000 for a mental hospital, Rs. 700 for a mental deficiency home and Rs. 550 for a home for senile and incurable cases, and the ratio recommended for these three types of institutions is 5:3:2.

14. We are in full agreement with the above recommendations of the Sub-committee as the ultimate objectives to be kept in view. In the meantime, we are putting forward our proposals for the short-term programme taking into consideration the existing inadequacy of training personnel and the possible insufficiency of funds. We suggest that radical improvements should be made in the existing mental hospitals in order to make them conform to modern standards. Provision should be made for all the newer methods of diagnosis and

treatment. The idea, which is now widely prevalent that these institutions are asylums and serve mainly the purpose of segregating mental patients from the general community, should be replaced by the conception of a hospital, which provides them with all the medical attention and sympathetic handling they require for the improvement of their condition. Apart from such remodelling of existing mental hospitals, we also recommend the creation of seven new institutions during the short-term programme, of which at least two should be established as early as possible during the first five-years period. These are the 200-bed hospitals in Calcutta and Bombay to which we have already referred. As will be seen from our proposals for the development of training facilities they are intended to play an important part in the creation of such facilities.

15. The existing seventeen institutions in British India are hospitals for the treatment of mental disorders. As far as we are aware, no homes of reasonable size and with adequate facilities for the reception and treatment of mental deficients and of incurables exist in the country. The need for an expansion of mental hospital accommodation is, under existing conditions, so great that we do not wish to suggest that any of the seven new institutions we propose for the establishment during the short-term programme should be homes of either of these two types. A decision on this matter can, however, be left to the Provincial Health Departments after they have had an opportunity of studying carefully the requirements of their provinces and of formulating plans to meet them. As regards the size of the new institutions, we feel that this is also a matter for decision by the Provincial Health Departments. We would, at the same time, suggest for consideration the desirability of limiting their accommodation to approximately 500 beds. Considerations of cost and the need for staffing these new institutions with adequate trained personnel have led us to suggest a smaller bed strength of 500 instead of the 1,000 recommended by the Sub-committee. For the hospitals at Calcutta and Bombay we have proposed a figure of 200 beds in each case, mainly because of the need for ensuring all possible speed in their establishment in order to develop facilities for training mental health workers. We hope, however, that their expansion may be possible without undue delay.

**(c) The Provision of Training Facilities for Medical men in India and abroad and for other types of Mental Health Personnel in India.**

16. The urgent need for the training of a large number of medical men and of other personnel for mental health work will be realised from the remarks of Colonel Taylor, which we have already quoted, regarding the unqualified staff now employed in many of the existing mental hospitals. Further, any proposals for an expansion of mental health activity can obviously be carried out only if there be a simultaneous execution of an intensive training programme.

17. As regards medical men, the ultimate aim should be to ensure that all those who are employed in mental institutions should possess a recognised Diploma in Psychological Medicine. It is also desirable that the Superintendent, the Deputy Superintendent and Senior Medical Officers in charge of different branches of work in a mental hospital should have a higher degree in Medicine or Surgery, such as M.D. or M.S. A proper clinical background in either of these specialities is of advantage to the medical officer even in the

treatment of mental patients, because a differential diagnosis of the condition of many of them may often require as much knowledge of general medicine and surgery as of Psychological Medicine. The possibility of error, with serious consequences to the patient, is great in respect of all who specialise only in their narrow fields. To quote Colonel Taylor's words "Every Psychiatrist has seen cases in which eye specialists have tried to correct failing vision by refraction in a patient suffering from General Paralysis of the Insane. Surgeons have frequently been guilty of operations on hysterics and psychiatrists have called the complaints of patients, somatic delusions, until they finally died of cancer."

18. One of the purposes of the tour which Colonel Taylor undertook at our request was to make an estimate of existing training facilities in the mental institutions in the country. In his view such facilities exist on a reasonable scale at Bangalore and at Ranchi. At the former, the mental hospital has, he says, all the essentials for treatment and that it "is recognised as a teaching institution for M.B.B.S., B.A. (Hons.) in Psychology of the Mysore University and the L.M.P. course of the medical school. The hospital is also recognised as a school for post-graduate work and some research work is already being undertaken." It is reported that the staff as a whole has attained a high standard of efficiency. As regards Ranchi, the European Mental Hospital already provides a post-graduate course of instruction which includes Psychiatry (Clinical and theoretical), Forensic Psychology and Mental Hospital Administration. The Instruction covers the ground in Psychiatry only, for the Diploma or M.D. in Psychological Medicine of London. This hospital is recognised as a training school for the Diploma in Psychology by the University of London, and a teaching school for nurses by the Royal Medico-Psychological Association. There are no facilities for the study of advanced Anatomy, Physiology, Histology of the Central Nervous System and experimental Psychology.

19. We understand that, nowhere in this country, are available all the facilities for the starting of a course for the Diploma in Psychological Medicine. We would suggest that, as early as possible, courses of training for this diploma should be developed in Bombay and Calcutta in association with the universities concerned. We have already referred to the desirability of establishing, as early as possible, a 200-bed mental hospital to help in the provision of such facilities. We understand that, in the vicinity of Calcutta, there is a small mental institution, the Lumbini Park Mental Hospital, which is being managed by the Indian Psycho-Analytical Society. The visiting physicians are reported to be all highly qualified. But owing to inadequacy of funds, the institution is at present being conducted in such a way as to afford no training facilities. Colonel Taylor states that "this institution, given adequate funds to meet the cost of expansion on modern lines, would in time become both a useful hospital and a good teaching school," and we recommend that this development should be assisted and advanced as early as possible. In Bombay the Child Guidance Clinic of the Sir Dorabji Tata Institute of Social Sciences is said to have made an encouraging start, although the number of children dealt with is small. Colonel Taylor reports that "This institution will be of great help in the training of both under-graduates and post-graduates in the study of problem children and child psychology." Advanced training in such subjects as Anatomy, Physiology and Histology of the Central Nervous System can



be provided in the Medical colleges in Calcutta and Bombay. We consider that the establishment of a Diploma in Psychological Medicine, with the necessary training facilities at both these places is of the utmost importance. We also suggest that, as soon as possible, similar diploma courses should be developed in the universities of other provincial capitals also.

In the meantime it is highly desirable that a certain number of carefully selected medical men, with some experience of work in mental hospitals in India, should be sent abroad for training. We suggest that provision should be made for sending at least 20 doctors during the first five years and another 20 during the second five years of our programme.

20. As regards the training of non-medical mental personnel, the types of workers required to be trained are occupational therapists, psychiatric social workers, psychologists, nursing staff and male and female ward attendants. Ranchi already possesses facilities for training occupational therapists. Both at Calcutta and Bombay facilities for the training of psychiatric social workers should be developed. The Sir Dorabji Tata Graduate School of Social Work and the Lumbini Park Mental Hospital, when developed, should be able to participate in such training. The development of facilities for the training of psychologists can, we think, be undertaken in Calcutta where the Applied Section of Psychology of the Calcutta University and the Lumbini Park Mental Hospital can help in such training. The training of nursing staff and of male and female attendants should be undertaken in all mental hospitals in India and the necessary facilities should, we recommend, be developed without delay.

**(d) The Establishment of a Department of Mental Health in the proposed All-India Medical Institute.**

21. The establishment of a Department of Mental Health in the proposed All-India Institute is calculated to serve at least three purposes. These are:—

(1) the development of facilities for the under-graduate and post-graduate training of doctors in all branches of psychological medicine and the demonstration to the provincial authorities of the standards to be aimed at, when similar training facilities are created by these authorities within their own territories;

(2) the promotion of research in the field of mental health and

(3) participation in the organisation of a mental health programme for the area in which the Institute is located.

22. All the above three purposes are, to some extent, inter-related. No programme for training workers in mental health will be complete without the provision of a field training centre, while the development of research in this subject also requires such a centre. The active participation of the Department of Mental Health of the proposed Institute in the organisation of the mental health programme for the areas in which it is located will help to secure the facilities for training and research in the field, the importance of which we have stressed.

**The Promotion of Positive Mental Health**

23. The pursuit of positive mental health requires the harmonious development of man's physical, emotional and intellectual equipment. Measures designed to create and maintain an environment conducive to healthful living and to control the specific causes responsible for

all forms of physical and mental ill-health are essential for promoting such development. The comprehensive programme of health reconstruction which we have recommended in this report, will, if implemented, constitute in itself no small contribution to the development of positive mental health in the community. Apart from provision for the prevention and cure of specific forms of ill-health, physical and mental, many of our proposals, *e.g.*, those dealing with health and physical education, the social aspects of our programmes for mothers and children, for the schoolgoing population and for industrial workers, the removal of slums and the creation of parks and other facilities for promoting community life should also help to raise the level of mental health in the community.

24. The development of an integrated personality, which will help the individual to adjust himself to the stress and strain of life, is essential if sound mental health is to be achieved and maintained. The mental health programme, if properly organised, should be able to assist in the endeavour to secure the unhampered development of human personality. Psychologists are agreed that the child requires a domestic environment which assures it a sense of security "based upon affection, consistency, fairness, regularity and serenity," if its mental development is to proceed on sound lines. At a later age the child's mental development is also influenced to a large extent by the teacher. An educational campaign for imparting to parents and teachers knowledge regarding the ways in which they can help the normal mental growth of the children for whom they are responsible, is an essential part of a mental health programme. Such education will supplement the provision that the mental health service will make, through child guidance clinics, to correct unsatisfactory mental or emotional states in children which, if left uncared for, lead to the development of "an aggressive anti-social attitude that is socially destructive, or to a regressive attitude which is destructive to the personality."

25. The mental health programme should also include within its scope educational propaganda for the adult. Opportunities for self-expression through work and recreational facilities are of great importance for the maintenance of a man's mental health. He should therefore be encouraged to create for himself as wide a field of cultural activity as is compatible with his main occupation. The development of hobbies helps to keep alive an active interest in life. A cultivation of the love of nature enables the individual to escape from the cramping limitations of his daily round of duties and to obtain, from the changing panorama of Nature, a refreshment which invigorates him without leaving behind any adverse after-effects. The arts also provide a varied field for self-expression outside a person's normal range of duties.

Economic insecurity probably plays a part in preventing the attainment of full mental health in the case of many adults. The view is widely held that unemployment promotes the incidence of psychoneurotic conditions and some evidence has been advanced in support of this view. The wider aspects of the social-security problem are clearly beyond the scope of our investigation. We may, however, draw attention to the fact that the provision of adequate medical care, preventive and curative for the individual, without regard to his ability to pay for it, is becoming recognised in all progressive countries.

as part of the National Social Security Programme. We have advocated in this report the adoption in India of this objective of a full and free medical service to all.

### 13. DISEASES OF THE EYE AND BLINDNESS

This subject was fully discussed and comprehensive proposals were made in 1944 by a Joint Committee of the Central Advisory Boards of Health and of Education. Its report deals with the problem both in its medical and rehabilitation aspects and, as the ground has been amply covered by this Committee in these two fields, we need do no more than commend its recommendations to the earnest consideration of Governments and all organisations, public and private, which are interested in promoting the welfare of the blind and in organising preventive and curative health work for those who are afflicted with eye diseases.



## CHAPTER XII

### ENVIRONMENTAL HYGIENE

#### Introduction

1. In this section we shall deal with the important problem of improving man's physical environment as an essential part of the campaign for promoting the public health. Adequate provision for remedial and preventive personal health services is no doubt essential for protecting the individual and the community. But the creation and maintenance of an environment conducive to healthful living may be considered to be of even greater importance because, in the absence of such provision, the services rendered by the doctor, nurse and other members of the health organisation will largely fail to produce the desired results. In the campaign for improved health, drugs, vaccines and sera can in no way replace such essentials as a hygienic home, good food, fresh air and a safe water supply.

2. Experimental studies carried out by Topley, Greenwood and their co-workers in London have amply demonstrated the truth embodied in this statement. The factors associated with the occurrence of epidemic diseases in human beings are so diverse, including movements of people who may be either protected against the disease by appropriate inoculation or not, that these medical scientists attempted to study the intricate phenomena accompanying such outbreaks by experiments on herds of mice using certain specific forms of infection. Without going into the details of these experiments it may be stated that the general conclusion was reached that, while protective vaccination would undoubtedly be of great value to those exposed to infection for a short time, it may prove to be of little benefit if the period of exposure to risk continues indefinitely. Under such conditions even the conferment of a high level of protection through artificial immunisation will not prove a sufficient safeguard for the community against certain diseases. We may quote the words of Professor Greenwood in which he sums up certain general impressions resulting from these studies. \*"The Victorian watchword that prevention, in the man in the street's sense, is better than cure is still not obsolete. It is a great deal better to provide clean houses and food than to pre-immunise people against the possible consequences of dirty houses and food, leaving the environmental conditions alone. It is fortunate for the world that pre-immunisation against the typhoid group was not discovered in the days of *laissez-faire*; had it been, many more thousands would have died of typhoid than actually did." It is clear that, while preventive inoculation and similar measures have no doubt their place in the fight against disease, adequate protection for the community can ultimately be secured only by the creation of those conditions which are fundamental to a healthy life.

3. The measures to be undertaken by the State in order to control the production, transport, distribution and sale of food under hygienic conditions have been discussed elsewhere in the report. In dealing

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\* Epidemic and Crowd-Diseases by Major Greenwood, D. Sc., F. R. C. F., F. R. S.—Publishers, Williams and Norgate Ltd., Little Russell Street, London.

with impersonal health services here we shall confine ourselves to the following subjects in the order indicated below:—

- (1) National planning for town and country, including housing—
  - (a) Town and village planning.
  - (b) Housing, rural and urban.
- (2) Public Health Engineering—
  - (a) Water-supply;
  - (b) General sanitation including conservancy and drainage;
  - (c) River and beach pollution;
  - (d) Control of insects, rodents and other vectors of diseases and
  - (e) Control of trades dangerous and offensive to the community.

It will be seen that we have divided the subject into two broad groups. The first deals with town and village planning or the utilisation of land to the best advantage of the community in order to meet its various requirements including the provision of space for residential accommodation, amenities such as schools, markets, places of worship and recreation grounds and the development of industry, as well as with the problem of constructing and maintaining hygienic homes for the people. The second group of services has been brought together under the common heading of 'Public health engineering'. As has been pointed out elsewhere, the modern tendency is to place the functions associated with such services as are included here in the hands of an engineer who has had special training to deal with the problems of environmental hygiene and to relieve the medical officer of these duties in order that he may concentrate on his preventive and curative medical work.

4. The subjects under consideration here are of such importance and some of them raise issues of such complexity as would seem to justify special investigation before decisions can be reached in respect of them. We have had neither the time nor the opportunities for a detailed consideration of these problems. We are therefore confining ourselves largely to certain general principles leaving their application to be decided after a review of the local conditions in each case. In the pages that follow we have put forward certain suggestions in respect of these problems and, although we feel that they do not constitute conclusions based on such a detailed consideration as their importance would require, we trust they will help to stimulate discussion and to facilitate further action.

## **TOWN AND VILLAGE PLANNING**

### **Introduction**

1. The purposes to be achieved by town and village planning include the following:—

(1) The utilisation of the available land to the best advantage of the community by making provision for all its needs. Land is required for the development of residential areas with such amenities as recreation grounds, places of amusement, markets, schools and centres of worship. There should be provision for the location of industries in such a manner as to prevent the smoke, noise and offensive effluents proceeding from them spoiling the health and amenities of the inhabited area.

(2) Most of the populated and urban centres in this country have grown up in the past without due regard to the principles of planning. Therefore an immediate task which must be faced is that of providing for an amelioration of existing slum conditions. The demolition of overcrowded and insanitary blocks of houses and their replacement by hygienically constructed dwellings, in surroundings which are pleasant and conducive to healthful living, constitute the most urgent need, particularly in many of the larger industrial centres. The removal of slums raises at once the question of housing the people deprived of their homes and rehousing plans therefore constitute an important part of clearance schemes.

Town and village planning must be concerned, at least indirectly, with the problem of housing also, although the primary object is that of securing a reasonable distribution of the available land between the varying needs of the people.

(3) The development of communications is such an essential part of community life that planning must include, within its scope, the provision of such facilities in the area covered by its operations.

(4) The aesthetic aspects of town and country planning should not be ignored. In both types of areas there is room not only for providing for man's physical needs but also for promoting his sense of beauty and love of nature which help him towards securing certain deep-seated satisfactions.

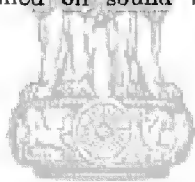
In considering these problems we have been greatly assisted by a report prepared for us by Mr. B. R. Kagal, Chief Administrative Officer at Jamshedpur, who undertook, at our request, a rapid tour of some parts of the country to study the problems of town and village planning and of housing. The more important parts of his report have been incorporated in Appendix 24 to our report.

### **The Present Position**

2. The present state of town and village planning in the various provinces of India has already been surveyed briefly in Volume I, Chapter X, of this Report. While it is true that some attempts have been made to regulate the growth of certain cities and to deal with slums and conditions of overcrowding in them by the creation of Improvement Trusts, the number of such Trusts, is so small, and, for various reasons which will be discussed later, the success achieved by them has been so limited that the total effect of such planning on the country as a whole has been negligible. Indeed it has often happened as pointed out by the Central Advisory Board of Health at its meeting in 1940, that, after costly slum clearance operations were carried out by Improvement Trusts, the cleared areas were permitted by the authorities concerned to be built over without regard to the requirements of light, ventilation and sound hygienic construction. Such failure on the part of the local health authorities to enforce the powers they possess for regulating housing has resulted, not infrequently, in defeating the specific purpose for which slum clearance was carried out by the Improvement Trusts. The haphazard growth of industrial concerns in residential areas has also taken place in many of the larger industrial towns and cities as the result of failure, on the part of the authorities concerned, to take appropriate action in the past. Slums have often grown around such industries and have helped to add to the congestion and insanitation of the areas concerned. Villages have frequently developed without streets and

without any attempt to regulate building construction. These remarks apply also to many of the smaller towns. As a result the orderly development of rural and urban residential areas has been woefully neglected in the past.

3. This state of affairs must not be allowed to continue. The Census of 1941 has revealed an accelerated rate of urbanisation in India and this tendency has received further impetus during the later years of the war: In the post-war period it is to be anticipated that new large-scale industrial developments, the active promotion of agricultural operations on a wide basis and the execution of large public works will, in all probability, help to create new townships and settlements and thus further the process of urbanisation. It is, therefore, of paramount importance to regulate the growth of towns in accordance with the principles of sound town planning and to make a determined effort to eradicate existing slums and to prevent conditions in which they can again grow and thrive. It is recognised that there are serious limitations to the improvements that can be effected in respect of existing built-up areas. These have grown during a number of years and it may not be easy to demolish and rebuild them in all cases. Tradition, prejudice, ignorance, a conflict of interests between the community and private individuals and the enormous expenditure that is involved are all factors to be reckoned with. At the same time, unless measures are taken now to retrieve the errors of the past and to ensure that new towns, cities and other inhabited areas are planned on sound principles, the problem we



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schemes which receive financial support from the Central exchequer will be scrutinised by him from the technical point of view before being sanctioned, during execution and on their completion. His professional advice will also be available to the provinces even in respect of schemes which are not supported by grants from the Centre.

7. We suggest that the Central Directorate of Town and Village Planning should function as an Information Bureau for town planners throughout the country and that the Directorate should be equipped with an adequate library and literature on the most recent developments in this field in other countries in order to make the information service that is provided as up to date and complete as possible.

8. As it is in the provinces that the major activities in connection with town and village planning will be carried out, the technical assistance to be provided to the Ministry dealing with this subject will have to be on a larger scale than that suggested for the Centre. But, before we go into the details of the composition of such a provincial technical organisation, we may consider some of the more important functions which will have to be performed in connection with the proposed planning. The carrying out of such functions will have to be regulated by legislation and we therefore offer the following suggestions regarding such legislation.

9. *Town Planning Legislation.*—The main provisions of town planning legislation should include, among others, (i) the reservation of land in and around a town within certain notified limits in order to prevent its development in a manner incompatible with the principles of town planning; (ii) the prevention of ribbon development, that is the growth of a town along a highway and (iii) the requirement that all local authorities, improvement trusts, building societies, industrial organisations, private estate development concerns and Government Departments should submit all schemes for land development or slum clearance to the Provincial Ministry of Housing and Town and Village Planning for previous sanction before such schemes are proceeded with.

It is suggested that the proposed legislation should empower Governments to declare, by notification, the minimum size of projects to be submitted for approval in terms of the acreage of land to be developed, the number of houses to be built or the number of persons expected to be housed.

10. We suggest that the following minima may be prescribed in respect of the size of a developmental area and of a housing scheme in order to make approval by the proper authority a condition precedent to the starting of operations, namely, a plot of over 15 acres in size or a housing scheme involving 100 or more houses or family units or a scheme for housing 500 or more persons.

11. We believe that town and village planning are Provincial functions. Legislation to regulate planning in respect of towns exists in the provinces of Madras, Bombay, the Punjab and the United Provinces but, as far as we are aware, no such provision exists in respect of rural areas. We consider that legislation should be enacted in all the provinces on a fairly uniform basis and that it should include, within its scope, both urban and rural areas. We therefore suggest that the Central Government should, in consultation



with town planning experts, draw up model legislation and recommend its adoption by the Provinces or, with their approval, seek the enactment of an all-India Act. In either case consideration should be given to the possibility of incorporating in the proposed legislation all the requirements that modern conceptions regarding town and country planning would suggest for inclusion. Compulsory acquisition of land is often an important measure to be adopted in this connection and, as this subject is also at present one within the jurisdiction of the provinces, we recommend that the existing law on this matter should be examined and that such modifications as may be considered necessary should be incorporated in the proposed model legislation.

12. *The provincial technical organisation.*—We consider it essential that the Provincial Ministry of Housing and Town and Village Planning should be able to call upon the services of a technical expert as its adviser, who may be called the Director of Town and Village Planning. The Provincial Director should have in the beginning three Regional Assistant Directors in the larger provinces. Their number may be suitably reduced in the smaller provinces.

The duties of the Director of Town and Village Planning will include, among others, the following:

- (a) To draw up master plans for such local authorities as may ask for them;
- (b) To determine, on his own initiative or at the request of individual local authorities, the area around each of them in which the development of land should be controlled, and to advise the Minister to notify such area as reserved for town planning;
- (c) To advise other government departments, improvement trusts, local authorities, registered housing co-operative societies and other organisations interested in town planning and housing, on the schemes they propose and to draw up schemes for them, if they have no competent technical advisers. If it is considered necessary to levy a fee on all organisations except government departments for the advice given to them, it is suggested that the fee should be kept to the minimum possible level in order to encourage all concerned to obtain the technical advice of the provincial town planning expert;
- (d) To examine schemes submitted to the Ministry for approval under the provisions of the proposed legislation and to advise the Minister on them;
- (e) To inspect schemes during execution and on completion, in order to ensure that they are carried out on approved lines.

The Director of Town Planning is not expected to interfere with the routine administration of the improvement trusts and other concerns. But, as has been pointed out above, it will be his duty to see that, in the execution of works by them, the prescribed standards are maintained.

13. While our proposal is that every scheme falling within the prescribed standards should receive the prior sanction of the town planning authority before execution is proceeded with, such legal provisions will have to be supplemented by routine inspections in order

to ensure that there is no contravention of the law. The Director of Town Planning and his organisation constitute too small a staff for the effective carrying out of such inspections. We, therefore, suggest that the Public Health Engineers at the district headquarters, the Assistant Public Health Engineers attached to the secondary units and the Public Health Inspectors in the primary units should undertake such inspections on behalf of the Director of Town Planning and bring to his notice cases of construction without the prior sanction of the proper authority. In the earlier stages of our programme there will thus be more effective supervision over unauthorised construction in the area under our scheme than in the territory outside it. The Regional Assistant Directors of Town Planning should, in the initial stages, concentrate attention primarily on the latter in order to ensure that a reasonable measure of compliance with the requirements of the law is enforced in this area also.

The Director of Town Planning should have a salary and status comparable with those of other heads of departments.

### **The Qualifications of a Town and Village Planner**

14. In India planning has suffered in the past from the fact that the recognised expert advisers to Governments have, in many cases, been civil engineers in charge of Public Works Departments. While some knowledge of engineering is no doubt necessary, a town planner is not merely an engineer. Similarly, while he should know something of architecture, the town planner is not an architect pure and simple. The examination for the Associate Membership of the Town Planning Institute of London gives some idea of the range of subjects with which a town planner should be familiar. The intermediate examination for this qualification has a paper dealing with elementary principles regarding construction of buildings and roads as well as surveying and levelling. In the final examination the subjects include: (a) the history of town planning, (b) town planning practice, (c) town planning in relation to architecture and amenities, (d) town planning in relation to engineering, (e) town planning in relation to surveying, and (f) the law relating to town and country planning. The student is required to have some elementary knowledge about sewerage and water supply. The details set out in the syllabus indicate that the candidate should have, in relation to sewers and drains, information regarding requirements in respect of population and general knowledge of capacity, gradients and sewage disposal. He must also be familiar with the relation of the distribution of water, gas and electric supplies and sewage disposal to "zoning".

We have indicated above, in some detail, the technical qualifications of a town and village planner because we consider it will be a mistake to continue the practice of entrusting this branch of public administration to a Civil Engineer who does not possess the special knowledge that planning requires.

### **Planning in Urban and Rural Areas**

15. *Large cities.*—In some of the larger and more congested cities of India, improvement trusts have been engaged, for some time, in slum clearance and the improvement of housing. These trusts have been created under different provincial Acts and they do not function in the same manner. For instance, we understand that the Calcutta Improvement Trust has no control over the erection of buildings on cleared areas while the United Provinces Town Improvement Act

makes the trusts the authorities responsible for operating, in the areas under their scheme the provisions regarding building and drainage in the provincial Municipal Act. The Delhi Improvement Trust was constituted by the Government of India by the application, under the Delhi Laws Act, of the United Provinces Town Improvement Act and this Trust exercises the right of enforcing the building and drainage byelaws of Delhi Municipality. It is understood that the Trust, in addition to such powers, imposes other conditions also, *e.g.*, those relating to the lease of land for building purposes. It maintains its own staff for inspection during the construction of buildings and also after occupation, in order to ensure that all the rules and regulations are satisfied.

16. We have described above these differences in the functions of improvement trusts in order to draw attention to one or two matters. In Calcutta the responsibility for slum clearance and the responsibility for enforcing hygienic standards of construction in the cleared areas have been separated and assigned to two independent authorities, namely, the Improvement Trust and the Municipal Corporation respectively. This is understood to have worked unsatisfactorily as the building byelaws of the city have not been effectively enforced and the purpose, for which clearance was undertaken, appears to have been defeated. On the other hand, in Delhi the Improvement Trust is carrying out, in the areas covered by its schemes, functions which should legitimately be performed by the municipal authority. This results in the maintenance of separate supervisory staffs by the two authorities for the exercise of similar functions in contiguous areas.

It seems to us that neither of these represents a completely satisfactory situation. It is deplorable that cleared areas resulting from costly demolition operations should be allowed to be built over without adequate control. At the same time, measures designed to remedy this defect should not result in creating, within the area of a municipality's jurisdiction, another body which usurps some of its functions.

17. Before we make suggestions to meet the difficulties indicated above we may state our view that, the establishment of improvement trusts is necessary in all large cities of India for dealing with large scale slum clearance and rehousing. We consider, however, that the responsibility for enforcing the law in respect of building construction, drainage and water supply, in the developed areas should rest with the local authority. It should be obligatory on the improvement trust, as on any other body or individual promoting large scale housing, to carry out the requirements of local byelaws regarding building, water-supply and drainage. In fact, as a responsible public authority, it does not seem unreasonable to suggest that the trust might provide even better standards than those laid down by the local authority as being applicable to all.

18. We realise that, under existing conditions, local bodies have, for one reason or another failed to a large extent to carry out the functions entrusted to them. We have made various suggestions in Chapter XVII, for improving the efficiency of local health administration. Apart from the legislative and administrative measures which have been suggested, we have included in our recommendations the appointment of public health engineers at three different levels of administration, namely, the headquarters of the province, the

district, and secondary unit, in order to assist in improving environmental hygiene including the enforcement of suitable standards for housing. We therefore believe that, if our recommendations are given effect to, local health authorities should be in a position to ensure greater compliance with the prescribed standards than they have done in the past. An improvement trust is at liberty, like any other corporate body, or individual undertaking the development of large housing programmes, to employ such staff as it considers necessary to supervise its own schemes and ensure sound construction and the fulfilment of the prescribed standards. Nevertheless the local authority, advised by its technical officers, will continue to be responsible for enforcing these standards. Housing is but a part of the wider problems of environmental hygiene for the solution of which the local health authority must remain primarily responsible.

19. In making this recommendation we are not ignoring the possibility that, under existing conditions, certain improvement trusts may be carrying out the function of enforcing housing standards in a more effective manner than the local authorities with which they are associated and whose powers they have taken over. In these circumstances we feel that, we must leave it to the Provincial Governments concerned to decide whether the present system or the one suggested by us should continue for the time being.

20. In order to indicate the comprehensive nature of the planning that can be undertaken in a large city we give below a master-plan prepared for one such city, which makes provision for the following:—

- (1) industrial zones with railway facilities;
- (2) areas for housing industrial labour in close proximity to the industries, with provision for amenities so as to make these self-sufficient townships;
- (3) extension of the Civil Station providing accommodation for upper and lower middle class citizens with their domestic servants;
- (4) location of business and civic centres on wide roads;
- (5) reservation of sites for public and quasi-public institutions in convenient localities;
- (6) ring roads separating external and internal traffic;
- (7) building sites for the poor within a reasonable distance of their places of work, with provision for amenities similar to those provided for townships;
- (8) parks and playgrounds distributed over the entire area;
- (9) canalisation of water-courses and diversion of sullage and sewage into a complete water-carriage system of drains and
- (10) wide arterial roads driven through the heart of the existing congested city.

21. One of the handicaps, from which existing improvement trusts have suffered, is lack of technical assistance. Every trust should be required to employ a town planner on its staff as soon as trained personnel of this class become available in sufficient numbers. Such technical assistance and the requirement that all schemes above a certain prescribed standard should receive the previous sanction of the provincial town planning authority before the commencement of operations, should suffice to ensure that the schemes carried out by improvement trusts will not be technically unsound.

22. We would suggest that these trusts should not be allowed to sell land freehold. It should be given on long lease for building purposes with such conditions as are necessary to ensure that the prescribed standards are observed.

23. We are suggesting in the next chapter that the development of housing should definitely be the responsibility of Governments but that local authorities and improvement trusts should be made the main instruments for discharging this responsibility. Priority should be given to housing schemes for the lower income classes.

24. *Other urban areas.*—The urban areas for which the establishment of improvement trusts is likely to be considered not feasible will, from the point of size and importance, be such as to make them suitable for inclusion in the district health organisation we have proposed elsewhere in the report. The local authority that should be made responsible for the planning of such urban areas should be the District Health Board. This authority should, as in the case of an improvement trust, be required to maintain on its establishment a trained town planner who will, in technical matters, be subject to the supervision of the Provincial Town and Village Planning Directorate. The public health engineering staff maintained by the District Health Board will be able to help, as has already been pointed out, to carry out effectively town planning administration.

25. *Rural areas.*—The rural areas present the most difficult problem from the point of view of planning. In certain provinces many villages have no streets or roads, the houses having been built indiscriminately over the village site. The reconstruction of built up areas on lines conforming to modern conceptions of planning will by no means be easy even in the larger towns and cities because of vested interests and of the high cost involved. For these and for certain other reasons it will be even more difficult to rebuild villages on any substantial scale within a reasonable period of time. Until the health organisation we have proposed is extended over the country and is sufficiently strengthened to enable it to take an effective share in rural planning, the provincial Town and Village Planning Directorate will find it difficult to secure suitable staff to undertake satisfactory supervision over the schemes that may be developed in rural areas. In these circumstances, we feel that however desirable it may be to replan existing villages, such planning may not be practicable as a short-term measure and that, during this period, attention may have to be confined to the lay out of new villages which may be established as the result of developments in industry, mining, agriculture or the settlement of demobilised personnel. In the case of all new villages we recommend that the provincial Director of Town and Village Planning should be consulted beforehand by the department concerned and that he should design the lay-out. Large scale road developments, electrification and irrigation projects may also stimulate the growth of village communities and if, with the initiation of such projects, planning principles are not simultaneously applied, there is a real danger of increasing the number of problems which we are seeking to solve. Road construction should be accompanied by adequate legal provision against ribbon development. Here again emphasis should be laid on the need for prior consultation between the planning authority and the departments concerned with the promotion of development projects.

26. There are certain aspects of village planning which have been emphasised by Mr. Kagal in the report which he has prepared for us. We commend these for consideration. We may quote his own words:—

“The technique of planning for villages is not different from that for towns. It has, however, to be modified according to the needs, characteristics, customs and standards of living. It is in this sphere that the knowledge of local conditions, customs and habits plays a very important part.

“The location of the market place in relation to the village, of the manure pits, the cattle-shed and grain-store in relation to the home are some of the problems that need special study and tactful handling. The principle of “neighbourhood units” adopted in the town can be worked into a village siting plan to enable one unit to serve several villages.”

27. The preservation of rural amenities is another aspect of planning for the countryside which should not be lost sight of. The provision of certain essential requirements for the maintenance of health such as protected water supply, drainage, markets and communications, is of course of fundamental importance. Apart from these, however, we consider it desirable that modern developments such as industrial and other projects of a remunerative nature should not be permitted to destroy the natural beauty of the countryside. As has been pointed out by Mr. G. M. Trevelyan, continued residence in cities is “not without deleterious effects on imagination, inspiration and creative power” while a holiday in the country enables a person “to drink in with the zest of a thirsty man the delights of natural beauty and return to the town reinvigorated in soul”. An orderly development of rural community life so as to promote economic and social welfare, without at the same time disfiguring the face of nature, is the ultimate aim that planning should keep in view.

### Location of Industry

28. We are concerned with the problem of industrial development only from the point of view of ensuring conditions favourable to the health and well-being of the workers and of the general community. We have considered the question in relation to the industrial workers in our chapter on occupational and industrial health. Here we shall confine ourselves to the question of the repercussion that the location of industry may have on the health of the general community.

29. The haphazard location of industries in inhabited areas must be controlled by proper legislation. Legal provision exists in certain provincial Local Self-government Acts for enabling the local authorities to regulate their location within their areas. For instance, in the province of Madras, municipal and non-municipal local authorities have power to regulate, by the issue of licences, the establishment of any factory, workshop or work-place in their territories provided these employ steam, water or other mechanical power or electrical power. It has been specifically laid down that the local authority has the right to refuse permission if, in its opinion, such location is objectionable by reason of the density of population in the neighbourhood or by the likelihood of nuisance being caused. We desire that provision for controlling the location of industry should be included in the proposed model legislation we have recommended earlier in this chapter. Such provision should be applicable to urban

and rural areas. It is desirable that the law should be sufficiently elastic to bring within its scope all industrial establishments which are likely to be detrimental to the health of the community, irrespective of the question as to whether electrical or any form of mechanical power is used.

30. We have already suggested earlier in this chapter that, whenever an industry is to be established, the lay-out should be submitted to the Ministry of Housing, Town and Village Planning for previous approval. This requirement should apply not only to factories but also to any residential accommodation for industrial workers. In order to ensure that this legal provision is properly carried out we would suggest that the Director of Town and Village Planning and his assistants should be given the powers of factory inspectors for inspecting and taking appropriate action in respect of any violation of approved plans.

31. A colony for industrial workers should not be permitted on a temporary basis for a longer period than three years and, even during this period, provision should be made for such amenities as roads, water, drainage, sanitation and lighting. Failure to make such provision will generally result in the creation of conditions which are harmful to the health not only of the workers but also of the general community among whom they live. Our attention has been drawn to the extremely unsatisfactory conditions under which labourers employed on Government works in the capital city of India have been forced to live. We trust that such conditions will not be allowed to continue.

### **Training Facilities**

32. There are no facilities in India for training in the subject of town and country planning. No degrees or diploma courses have been instituted in the universities. The subject is not taught in any of the existing engineering colleges. Nor has there been in the past a demand in the country for the services of trained town planners. The proposals we have made here will, on the other hand, require the creation of a large body of trained workers in this field. We make two recommendations in this connection. One is that a certain number of selected individuals should be sent to Europe and America for training in the subject. The other is that town planning experts may, if necessary, be recruited on short-term contracts from abroad and that training centres should be set up at least in a few universities in the country.

### **The Recruitment of Town-planning Officers for the Centre and the Provinces**

33. During the short-term programme it may be necessary for the Governments in India to obtain the services of town-planning experts from abroad on short-term contracts. We consider it desirable that the Central Government and at least the major provinces should initiate town and village planning activities on the lines suggested in this chapter with the least possible delay. If the programme of training suggested by us proceeds satisfactorily a sufficient number of trained men will, in due course, become available to extend the service into the smaller provinces as well as for expanding the work already in progress in the larger ones.

### **The Establishment of an Institute of Town and Rural Planning**

34. We believe that the advancement of science, in whatever field it may be, will be promoted by the creation of suitable scientific and technical societies. These help to stimulate discussion and to develop scientific activity. They also help to establish desirable standards of professional conduct and efficiency. In their report the Industrial Commission (1918) on Scientific and Technical Societies said, "we are of opinion that the interests of India demand the establishment of Indian institutes, societies and associations analogous to the Institution of Civil Engineers, Chemical Society and the British Association for the Advancement of Science". We believe that, in due course, the development of town and country planning in India will be served by the creation of such an Institute of Town and Rural Planning. We may draw attention to the Road Congress which has been established with the object of promoting the science and practice of road-building and maintenance and of providing a channel for the expression of the collective opinion of its members on all matters pertaining to roads. Its membership is open to qualified engineers who are or have been connected with roads, to other persons of scientific eminence who are engaged in a responsible capacity in scientific work allied to road construction and maintenance as well as to persons who are engaged in the administration of roads or road transport, in business connected with the construction and maintenance of roads or in the manufacture or sale of material used in connection with the making or repairing of roads or road transport vehicles. The Congress has a Governing Body which provides representation for official engineering departments, engineers in Indian States, district board and municipal engineers and the general body of members of the organisation. The creation of a similar organisation for town and village planning will constitute an important step forward in promoting the development of this activity on sound lines and in advancing the cause of education and research in the subject.

### **The Long-Term Programme**

35. In our view the implementation of the recommendations outlined in this chapter can and should be started with as little delay as possible during the short-term programme. Inadequacy of trained personnel and lack of funds will naturally make progress slow, particularly in the early stages. The replanning of established cities and towns, involving as it does large slum clearance and rehousing schemes, must necessarily take time and can be accomplished only in stages. In regard to the planned development of our urban and rural areas it seems irrelevant to speak of two specific stages of short and long-term effort. Certain measures must, however, take precedence over the others. These include the creation of facilities for the training of the required personnel, the establishment of planning directorates at the Centre and at least in the major provinces and the enactment of the necessary legislation on the lines indicated by us. These and such other recommendations of ours as can be carried out without delay should receive early attention. They will constitute the short-term programme while the continuing range of activity designed to promote urban and rural land development on lines best fitted to serve the interests of the community will remain an unending task, shaped and guided as it will be by changes in social outlook and by the growing complexity of the community's needs.



## CHAPTER XIII

### HOUSING, RURAL AND URBAN

#### Introduction

1. Housing and town and village planning must be considered as being complementary to each other. Housing in its wider sense is concerned with the development of residential areas in such a manner as to provide for the people hygienic dwellings in pleasant and healthy surroundings, with facilities for recreational and social activities. Planning is concerned with the equitable distribution of the available land according to the various needs of the community, which include the provision for residential and industrial areas, space for broad thoroughfares, parks and gardens, and further development. Thus the planning of land distribution and the development of housing seek to achieve jointly the purpose of transforming the physical environment in order to create suitable conditions for healthful living.

2. The modern conception of housing is against the idea of creating a conglomeration of buildings erected without planning and often resulting in mere mechanical extensions of existing urban centres. On the other hand, in progressive countries, advanced thought in regard to the planning of land development and the provision of housing for the people favours the creation of what is known as the community unit. We may indicate what we mean, by a quotation from Catherine Bauer's "Modern Housing" "The ideal has undoubtedly been the self-contained regional town, complete with assorted industries, and agricultural belt and full facilities for social life. This is the one way to carry the premises underlying modern housing and planning through to a really satisfactory conclusion. The building of completely new cities, of a size and extent limited in advance and located scientifically in respect of natural resources, manufacture, and distribution, is the only way in which the use-standards embodied on a small scale in the best modern housing can be enlarged to include all of modern human environment".

3. It will thus be seen that the new outlook is tending towards the promotion of land development and housing as a co-ordinated process in order to assist the growth of community life, including employment, on a rational basis. We believe that, howsoever difficult the housing problems of India may appear to be at present, we should approach their solution from this point of view. Whether it be rural or urban areas, the provision of hygienic homes for the people and of facilities for full community life are common ideals to be realised. The villages, with their sparsely distributed population and the simpler habits of their inhabitants, whose vocations are mainly confined to agriculture and cottage industries, present a less complicated problem than the towns, with their requirements based on industrial development and populations living under intensely congested conditions.

#### Existing Housing Conditions in Urban and Rural Areas

4. Housing conditions in India present a deplorable picture. Statistics of building and house construction are not available, but

the following figures for inhabited houses relating to India as a whole including the Indian States are taken from the Census Report of 1941:—

Census year	Average number of persons per house (British India and Indian States)
1911 . . . . .	4.9
1921 . . . . .	4.9
1931 . . . . .	5.0
1941 . . . . .	5.1

When it is remembered that these figures relate to houses of every description and size, from the one-room tenement to the large mansion, and include even temporary structures of flimsy construction so long as they are used for habitation, the value of these averages, for indicating the true extent of housing accommodation available to the people, is doubtful. One fact emerges. During the past few decades the rate of growth in housing has not kept pace with the rise in population.

5. A brief survey of existing housing conditions has been attempted in Chapter X of Volume I of our report. It is in no sense comprehensive in scope or complete in detail. We have given some of the impressions that we gained during our tours, of the terrible conditions of housing in some rural and urban areas and in particular of the appalling overcrowding in industrial areas. The single-room tenement is a common feature of even many of the more recently constructed housing accommodation in industrial areas. It often houses more than one family and in any case has to serve as living room, kitchen and bedroom. The sanitation of such tenements is usually inadequate and of a very rudimentary nature. Even where blocks of single rooms have been built for workers, the latrine and washing accommodation is usually quite insufficient. The War has greatly aggravated overcrowding in the great industrial areas. Thousands of workers have been drawn to them by new war industries or by the expansion of old ones, but little attempt has been made to provide the additional accommodation required. The result is that conditions in Calcutta, Bombay, Madras, Cawnpore, to mention only a few cases, are indescribable and intolerable. Thousands are without any home or shelter and have to live and sleep on pavements, verandahs, in open spaces, under trees, in cowsheds or in any temporary shelter. The Whitley Commission wrote in 1930:—

“Neglect of sanitation is often evidenced by heaps of rotting garbage and pools of sewage, whilst the absence of latrines enhance the general pollution of air and soil. Houses, many without plinths, windows and adequate ventilation, usually consist of a single small room, the only opening being a doorway often too low to enter without stooping. In order to secure some privacy, old kerosene tins and gunny bags are used to form screens which further restrict the entrance of light and air. In dwellings such as these, human beings are born, sleep and eat, live and die”.

Conditions in urban areas are much worse today.

6. Provincial Governments have taken very little interest in the development of housing estates or in providing working class accommodation. The number of houses built by Improvement Trusts for the poorer section of the population, for the relief of overcrowding, or

for those displaced by slum clearance schemes, has been negligible. Most of the progress made in the housing of industrial workers has been by railways and other authorities and by large employers of labour, many of whom have built quarters and housing colonies for their employees. Some are satisfactory, but many are still below a desirable standard for the low-paid workers. Private building activities are mainly for the benefit of the middle and wealthier classes.

There are laws in the major municipalities dealing with the prevention of overcrowding and the observance of elementary rules of hygiene; and they also exist in some of the enactments relating to smaller municipalities. But the authorities have shown little or no interest in their enforcement; and very few local bodies have attempted to control or to encourage the development of housing on proper lines in urban areas.

7. In rural areas, houses are without water supply and latrines; lighting is inadequate or non-existent; many are in a state of disrepair, and without ventilation. Sometimes, the industrious housewife, with her general sense of tidiness, endeavours to keep the inside of the house clean and her brass utensils polished; but she is generally oblivious of or indifferent to the defects in the sanitation and cleanliness of the environment.

8. There is practically no control of rural housing throughout the country, although in Chapter X of the Punjab Colony Manual, the Punjab Government gives detailed instructions regarding the selection of sites for villages in colony areas and the manner in which such villages are to be laid out. No standards have, however, been prescribed for the dwellings to be built in these villages. Recently, the Punjab Government has decided to extend village planning to:

- (a) a district board area where urban conditions have developed because of close proximity to a town, when it is found that, for any reason, it is not possible to extend the boundary of the town so as to include the rural area under consideration;
- (b) large villages of the size of small towns which, for one reason or another, cannot be notified as small towns;
- (c) villages found on survey to be tuberculosis-ridden and
- (d) new villages which are springing up at important meeting points of main roads in different parts of the Province.

### **The Impossibility of making an Estimate of Housing Requirements**

9. This brief review of existing conditions has not taken into account the continuing growth of India's population. During the ten years from 1931 to 1941 the population of the country, as a whole, increased by 50 millions or about five millions annually. In the absence of reliable statistics, even a rough estimate of the number of houses required for the country, taking into consideration the rate of population growth, the death rate and other factors, is almost impossible. There are also social changes which affect the housing problem. The disintegration of the joint family system, which will increase in tempo with industrialisation, and a rise in the standard of living, may well result in a demand for housing accommodation not less pressing than that caused by the growth of population. During the two decennial periods, 1921-31 and 1931-41, the net

increases in houses were 4.8 and 8.5 millions while the corresponding increases in population were about 30 and 50 millions. These represent average annual increases in population to the extent of three and five millions respectively during the two periods. The new houses built, during the two periods, were 18 per cent and 17 per cent of the respective annual increases in population. In spite of these increases, the density per house rose from 4.9 in 1921 to 5.1 in 1941.

10. Without further data than are now available, it is not possible even to hazard a guess as to the extent of new construction necessary for providing housing accommodation of a reasonable standard for the existing population. A definition of what that standard should be would influence the estimate of the number of new houses required, because a large percentage of existing houses would be condemned as unfit for human habitation by any reasonable standard, and another large percentage would require extensive improvement before they can reach the required standard.

#### **Recent Housing Developments in Western Countries**

11. We may briefly indicate some recent developments in Western countries in national housing programmes. Between the two world wars the provision of adequate housing for the people was recognised in most European countries as an urgent and important social problem. Governments accepted the view that "housing has become a public utility" and that "the right to live in a decent dwelling has taken its place in the 'national minima'—the right to good and abundant water, to sanitation, to adequate fire and police protection, to the use of paved and lighted roads, to education, to a certain amount of medical care, and, in most European countries, to various forms of social insurance".\*

12. These national housing schemes have certain features, which include control by a public authority over housing standards and financial aid directed towards promoting the building of houses of the required quality and in sufficient numbers, and the maintenance of the scales of rent at reasonable levels. In order to ensure quality, some countries have organised "national agencies for establishing standards, for supplying information, education, plans and technical advice, and for conducting experiments in materials and methods." In the United Kingdom, the Ministry of Health has issued manuals of type design and procedure, and sanctions all plans submitted by local authorities before Government aid is given. In Germany there was, before the War, a State Society for Housing and Building Research, which published a number of reports and investigations, and also conducted many experimental housing developments in great detail.

13. Local authorities in the United Kingdom have been entrusted with the responsibility for working class housing by a series of Acts. Every local authority must review periodically the housing needs of its area and submit to the Government proposals for the provision of new houses for its working class population. By the Housing (Financial Provisions) Act, 1938, grants from the Exchequer vary from £5-10.0 per house per annum for 40 years in respect of accommodation for the rehousing of persons displaced in pursuance of clearance and redevelopment operations to a graded payment ranging

\* Modern Housing by Catherine Bauer.

from £11 to £25 per flat per annum for the same period in the case of blocks of flats built on extensive sites. Housing for members of the agricultural population is subsidised to the extent of £10 per house per year for 40 years, increased in exceptional circumstances to £12 per year. Local authorities are required, as a general rule, to make contributions from their own funds on the basis of 50 per cent. of the Government contribution, although in respect of agricultural housing their contribution is only £1 per home per annum for 40 years.

14. Some idea of the extent of housing that has been made available and of the financial implications of the national housing programme may be obtained, for the period intervening between the two wars, from the following quotation from the "Synopsis of Hygiene" by Jameson and Parkinson:—

'In November, 1918, the number of houses in England and Wales was just under eight million. From the end of the war to the 31st March, 1940, about four million new houses were provided in England and Wales, of which over a million were built by local authorities and about three million by private enterprise, and an increase of about 50 per cent. over the number of houses in existence at the Armistice. Since the inception in 1933 of the five years programme for the clearance of the slums more than a million people have been removed from slum houses into new houses. The total annual contribution from public funds in respect of housing was about £19,000,000 in 1938-39 of which sum approximately £3,800,000 came from local authorities. . . . Government subsidies are now available only in respect of housing accommodation required for the abatement of overcrowding, slum clearance and the rehousing of the persons displaced. Special assistance is given, however, towards the provision of houses for members of the agricultural population'.

In view of the housing shortage brought about by the second World War, and the implications of the social security programme, the progress of housing operations in England must be far greater than it has ever been in the past.

### OUR RECOMMENDATIONS

15. We have not had the opportunity of studying the housing problem in such a manner as to enable us to offer detailed suggestions regarding the formulation of a national housing policy. Many aspects of this question, such as finance, the procurement, standardisation and price control of building material, the regulation of building construction through public and private agencies, and many allied subjects of fundamental importance, fall outside our sphere of enquiry. Our recommendations are couched in general terms and are mainly concerned with the importance of housing and planning to health.

16. In India a long-term housing policy, comprehensive in its scope and modern in its outlook, is essential for a satisfactory solution of the problem. The objective to be attained is the creation of

hygienic houses in sufficient numbers and of adequate size, in "sanitized" areas, equipped with all the facilities necessary for community life. The execution of such a programme will be possible only through a period of many years.

17. The main factors involved in the promotion of large scale housing schemes are: (1) the availability of land; (2) the provision of streets, water supply, drainage and other utilities to serve the common purpose; (3) the production of building material of the required quality at reasonable prices; (4) cost of the execution of the schemes and their maintenance, when completed. A housing programme can only be carried out successfully if Governments, local authorities and improvement trusts are prepared to enter the field with large scale housing schemes of their own, and to stimulate co-operative and building societies and private interests to more satisfactory performance, by financial and technical aid and the rigid enforcement of better standards. Governments and public authorities can perform the following functions:—

- (i) the planning, execution and regulation of housing programmes including participation by local authorities and improvement trusts in house construction and maintenance;
- (ii) the grant of financial assistance by long-term loans at low rates of interest, or grants-in-aid;
- (iii) the prescription and enforcement of standards and
- (iv) the promotion of housing research.

#### **Regulation of Housing Activities**

18. It has been pointed out by Mr. Kagal in his Report that land is plentiful in India and that with the proper distribution of industry and planning of land, it should be possible to control land values. Yet, we had evidence, during our tours, of the difficulty experienced by the authorities in acquiring land which was suitable for housing estates. The unearned increment, which accrues to the owners of land near towns and industrial areas owing to urban development, has a profound effect upon planning. Uncontrolled freedom to use such land for any purpose may be detrimental to the community, and some check should be exercised upon the extent to which owners of land may exploit the community for profit. We, therefore, recommend that the provisions of the Land Acquisition Act, 1894, and of all other legislation governing the acquisition and ownership of land be reviewed with a view to making such amendments as will remove the present obstacles to the acquisition of new lands for building and planning purposes, and to the control of the incremental value of land suitable for housing estates and village development.

The production of building materials of good quality at reasonable prices is a technical matter on which expert advice is required. It is essential, however, for any post-war housing programme, that building costs should be reduced to as low a figure as possible, commensurate with improved standards and satisfactory conditions for the labour employed. This is a matter which should interest the Central and Provincial Public Works Departments, and we would call the attention of the authorities concerned to the Report of the Expert Mission which was appointed by the Ministry of Works in the United Kingdom to survey American practice in the design and construction of buildings, in equipment and finishing, and the use of materials.

with a view to securing in the United Kingdom in the post-war period (a) increased speed in output, (b) reduced building costs, (c) improved standards of equipment and finishing, and (d) improved conditions for labour. An enquiry on similar lines in this country is important and should be started as soon as possible.

### **Functions of the Provincial Government**

19. Upon Provincial Governments must rest the primary responsibility for dealing with the problem of housing and town and village planning and for developing and executing housing schemes within their respective areas. (The responsibility of the Central Government for the centrally administered areas is that of any other Provincial Government.) This cannot be evaded by leaving it to private building interests or employers of labour. The housing of the people is essentially a State responsibility. It may, of course, be delegated under suitable conditions and in defined areas, to local bodies or public authorities such as Improvement Trusts. Elsewhere, we have pointed out that every available agency must be utilised if a comprehensive programme is to be planned and executed within a reasonable time. But the Government concerned must be responsible for ensuring co-ordinated progress and for making or encouraging others to make a determined effort to provide more and better houses for the people. It is partly on account of this that we have recommended the establishment in each province of a Ministry of Housing and Town and Village Planning which will be charged with the responsibility for the preparation and execution of new housing, and housing improvement schemes, slum clearances and urban and rural planning. We consider that the importance of housing and the planned development of the towns and villages fully justifies the creation of a separate Ministry which will be responsible for the planning and execution of a province-wide programme. Only thus will this urgent problem receive the undivided attention of a single department and the determination of policy by Government at the highest level.

20. There is no doubt that Provincial Governments will not be able to provide, from their own resources, the finance necessary for a bold and comprehensive housing programme, and they will be entitled to look to the Centre for financial assistance. It has been suggested in some quarters that an All-India House Planning Commission should be established, to which the Centre would give grants-in-aid or loans. There may be constitutional difficulties in the way of such a proposal, on which we do not propose to express opinion. But we do recommend that Provincial Governments should consider the establishment of a statutory body under the direction and control of the Ministry of Housing and Town and Village Planning, with financial resources and power to plan and execute a province-wide house construction and town and village development programme on a 20-30 year plan, in 5 yearly stages.

21. In recommending Provincial Ministries of Housing and Town and Village Planning, we have not ignored the fact that housing constitutes the most important part of the physical environment which continuously influences man's health and well-being. The Provincial Ministry of Health, therefore, is deeply concerned in the proper execution of any housing schemes and should be responsible for the control and enforcement of minimum standards in the design

and construction, not only of houses, but also of the environmental amenities, such as water-supply, sanitation and recreation. The two Ministries must work in close co-operation with one another and the staff of the Ministry of Health must, at all stages, be in contact with those who will be responsible for the execution of housing schemes and town and village planning. A more detailed reference to this will be made later.

### Functions of the Local Authority

22. We have already stated that, in England, local authorities have been responsible, for nearly a century, for the control of State-aided housing. In Holland and Germany, it is understood that city corporations "are responsible for all housing in receipt of public aid, that of co-operative societies as well as their own construction." In France, semi-official autonomous organisations known as Public Housing Offices are entrusted with the task of controlling public-aided housing while in Vienna where housing developments of an extensive nature took place prior to the recent war, the municipal authority concerned itself with all aspects of the problem, including regulation, financing, construction and experiment. (We need hardly say that these remarks refer, in respect of the Continental countries, to the period intervening between the two World Wars and not to the present time). We suggest that, in India, loans or grants by Provincial Governments to finance housing schemes should be administered by local bodies subject to such rules and regulations as these Governments may prescribe. It seems desirable that, as in the case of England, each local authority should be made to contribute a suitable proportion of the cost of such schemes.

23. The recommendations we have made for provincial and district health administration will, if implemented, establish certain new local authorities in place of existing ones. We visualise the creation of district organisations to deal with health, education, public works and communications, in order to provide more favourable conditions for efficient administration. We also envisage the establishment of co-ordinating bodies, on which these authorities will be represented, in order to ensure that their activities are integrated and directed towards certain common and desirable ends. It is not easy to state precisely how these changes may affect the administration of the Provincial Government. We assume, however, that the Ministry of Health will deal directly with the District Health Board, whereas the Ministry of Housing and Town and Village Planning will deal with whatever local organisation or organisations may be concerned with housing and planning. Matters which require the attention of more than one district organisation, may be dealt with by the co-ordinating body referred to above.

In carrying out a province-wide housing and planning policy in urban and rural areas, the work of enforcement of standards etc., from the health point of view, will fall upon the district health organisation and its officers. It will possess a staff of public health engineers, with suitable and qualified assistants, who will be in a position to advise and assist local authorities in prescribing and ensuring health standards in construction and planning work. On the other hand, the actual construction and maintenance of housing colonies will be carried out by the district agency which deals with public works, and which, in this connection, will be under the



control of the Ministry of Housing and Town and Village Planning, or the authority to which the Ministry has delegated its powers. It is essential to secure co-ordination between the various units of the administration in order that development schemes may be executed with the greatest possible despatch.

### **Functions of the Improvement Trust**

24. Improvement Trusts can perform most valuable functions in connection with slum clearance and the re-housing of dispossessed inhabitants in large towns and cities. Slum clearance involves the re-building and re-planning of the cleared areas and this can also be undertaken by Improvement Trusts. We advocate placing the work of re-building in these areas in the hands of the Trusts and not in the hands of private enterprises. If the land is leased out or sold in blocks, building by private agencies is not likely, conditions in India being what they are, to yield such satisfactory results as building by a public body, such as an Improvement Trust, on well-planned lines. We have noted that few of the Trusts have adequate technical advice available to them in their work of planning and housing construction. We have recommended, in the last chapter, that each Improvement Trust should be able to employ a technical officer trained or experienced in town planning. With the strengthening of their general engineering and public health engineering staffs, the local authorities should be able to exercise better supervision, than in the past, over the housing schemes within their areas.

### **Housing Standards**

25. Standards must be prescribed by the Ministry of Health and enforced by local authorities. The public health engineering staff maintained by the District Health Boards will, as already stated, carry out the necessary inspections and other duties in respect of all housing, whether constructed by public or by private agencies. The fact that this supervision will be the function of the public health engineering staff, who are independent of the department or departments responsible for construction, should help to secure a more effective check on the quality of the work carried out, whether by government, public authorities or private interests.

26. The following are some general recommendations regarding standards to be prescribed:—

(a) It has been estimated that the minimum accommodation required per head is 100 sq. ft. for an adult and 60 sq. ft. for a child. It may be difficult to ensure this for all within any measurable time. We are satisfied, however, that in any new construction the minimum floor space for a room should be 120 sq. ft. We understand that in some municipalities the minimum floor space prescribed is 80 sq. ft. or even 50 sq. ft. These standards are too low.

The proportion of window to floor area in living rooms will, of course, vary in accordance with climatic conditions and the requirements of light and ventilation. Uniform standards in India may not be possible, but we recommend that Provincial Governments should prescribe and enforce adequate standards regarding these matters.

(b) We are strongly of the opinion that the use of the single-roomed tenement by a family should be condemned. It is not necessary to enter into any elaborate arguments in support of this opinion, as the single-roomed house is obviously unhealthy and

renders privacy and the decencies of family life almost impossible. In our view no house or portion of a house intended for occupation by a family should consist of less than two living rooms with a separate kitchen, a bath-room and latrine and in the warmer parts of the country, a verandah. In hill stations, this verandah may be replaced by another room. One-room tenements should be restricted for occupation by single persons and should be adequately provided with common kitchen, bath and latrine accommodation.

(c) The proportion of the built-up to the total area should be smaller in rural districts and small towns (panchayats and small municipalities) than in the larger towns. In the former, houses should have sufficient open land adjoining them for the erection of a cowshed and for the disposal of refuse and manure. Minimum set-backs, side and rear spaces should be regulated by local authorities in both rural and urban areas.

(d) The walls, floors and roofs of houses should be so constructed as to prevent dampness and also provide insulation against the easy transmission of heat, cold and noise. In the design, as few opportunities as possible should be given for the harbourage of vermin.

(e) There should be statutory provision for water-supply, drainage and refuse collection for every house. The standards to be prescribed will have to vary according to the facilities available, but they should, in all cases, be approved and subject to inspection by the local authorities.

(f) The provision for excreta disposal will also vary, but certain minimum standards should be prescribed and enforced. We would recommend that, wherever land is available and the owner of the house can afford the expenditure, the health authority should enforce the installation of the water carriage system, small septic tanks and soil absorption systems for the effluent being provided. Such disposal is eminently desirable in respect of institutions such as hospitals, jails, schools and students' hostels. Apart from enforcing such provision by law, every encouragement should be given to enable owners, wherever land exists, to provide themselves with this sanitary convenience which, from the point of view of construction and maintenance, is not costly.

27. The above suggestions should be embodied in rules or regulations and be made gradually applicable, during the short-term programme, to all new house constructions or alterations of existing houses in the areas under our scheme. During the first five years, these rules may be made applicable to the larger urban centres and industrial housing schemes; in the next five years, they may be extended to the rural areas also. We do not imply, thereby, that the problem of the regulation of housing conditions in the rural areas is less important; but if rules are to be administered and enforced, there must be adequate staff, and for sometime the task of enforcing these requirements in urban centres will absorb all the energies of the organisation we have recommended. Later, as staff increases in numbers and efficiency the rural areas will have to be tackled.

28. In the areas outside our scheme, we expect that the enforcement of these rules and regulations may not be so complete or satisfactory as in those covered by our organisation. It should, however, be possible for municipalities with health officers and the better

trained and paid staff, which we recommend elsewhere, to enforce these rules and secure a reasonable measure of compliance with them.

29. These rules, when brought into force in any area, should provide that every person contemplating the alteration of an existing house or the erection of a new one must apply to the health authority and submit plans for examination and approval by its technical expert, the public health engineer or the health officer in his absence. Provision should be made for the owner to give notice to that authority when the building is completed and to obtain a "certificate of conformity with approved plans and standards" before occupation.

30. These standards apply to all construction whether undertaken by public or private agency, by industrial concerns, building societies, Governments, municipalities, private contractors, etc.

31. In a large housing construction programme, temporary provision will have to be made for the housing of labour employed in the works. It is essential that, in the interest of the public health, plans and specifications for the necessary accommodation and for arrangements in respect of such essential requirements as water-supply, latrines, urinals and disposal of excreta and rubbish, should be made, after being sanctioned by the local authority, before constructional operations are started. Less rigid standards than those for permanent housing will be prescribed for temporary establishments. The authority to prescribe such standards should normally be the local health officer. In the case of works above a certain scale, there should be an appeal from the decision of this officer to the Director of Health Services, whose verdict should be final.

32. We recommend also that the Ministry of Health should scrutinise the housing schemes of all other government departments in order to ensure that they conform to the proposed minimum standard.

33. We further recommend that when Revenue or other Departments of Government make grants of Crown land for housing, to individuals or communities, a condition should be laid down requiring that the houses should be built according to standards prescribed for the area concerned. We suggest this as an additional precaution in order to ensure the enforcement of the housing standards.

### **Type Plans**

34. The legal enforcement of housing standards is only one method of approach towards raising the quality of construction. We believe that an equally important method is that of making technical advice on the subject as widely available as possible. One of the methods is the preparation of type plans, covering a considerable range of cost, material and sizes. The plans and estimates should be sufficiently detailed to be of assistance to the wide variety of people for whom they are intended. They will have to be based on local rates of cost, as far as possible, and should incorporate locally procurable material. These type plans should be made readily available to the general public.

In rural areas, it may not be possible to enforce building standards in the early stages of development as strictly as in the towns. The recommendations, which we make hereafter, will, we believe, promote house construction on more satisfactory lines. Public health

engineers and their staff should be instructed to give free advice regarding ventilation, lighting, drainage and other matters connected with house construction.

### **Housing Research**

85. Housing research should be directed towards the evolution of various types of building suited to the requirements of different localities and climatic conditions and to varying income groups. To this we attach the greatest importance. Such investigations should include the development of local resources in building material of reasonable quality and durability. We recommend that building research should be initiated at engineering colleges and at special institutions where necessary facilities exist, for instance, the Forest Research Institute. In the United States a considerable amount of scientific research is regularly undertaken, by Governments, Universities, professional institutions, trades associations, manufacturers and organisations financed by private benefactors. Great advances are expected in the development of building materials, more particularly in plastics, non-ferrous metals, composite and temporary materials, and materials used for thermal insulations. There is a large field for research in prefabrication or the factory production of buildings and large parts of buildings.

### **All-India Housing Research Institute**

We have referred, earlier in this chapter, to a State Housing and Building Research Society in Germany which carried out valuable work in this field. There is also a Building Research Station in the United Kingdom which co-ordinates research activities. We recommend the establishment, with Government assistance, of an all-India Building Research Institute or Station. It should be a centre of active research in building problems, whose staff will be able to give technical advice to public and private bodies in the planning and execution of building schemes. Membership of this institute should be open to all interested in the improvement of house construction and planning generally.

### **Housing Schemes under Private Auspices**

86. On however generous a scale active participation by the State and State aid in a comprehensive programme of housing construction and improvement may be provided, rapid progress will need the help of every available agency. We have already drawn attention to the fact that, in England, of about four million new houses constructed between 1918 and 1940, three million were built by private enterprise. In India also, the scope for individual enterprise and organisations will be very large. Non-official agencies interested in the housing problem include (1) employers of labour in factories, mines, plantations, docks, railways etc. and (2) the building trade. Employers of labour can render great assistance financially and in other ways in the promotion of a housing programme through co-operation with Governments and public authorities.

87. The building trade in India will require considerable organisation and development if it is to play its part satisfactorily. With certain notable exceptions, private organisations and individuals, concerned with the building of houses for the people, lack technical guidance and knowledge in the planning and execution of their works.

A large part of constructional activity falling outside what may be termed "public works" normally goes on without any technical advice at all. Such technical advice will only become available on the scale that is necessary when the number of qualified engineers and architects in the country is considerably increased. The provision of greater facilities for such training should, therefore, receive early attention. In the meantime, a stricter enforcement of building standards, and the undertaking of house construction by local authorities or improvement trusts with the help of their qualified staffs, which we have already recommended, should help towards a general raising of the standards of construction.

38. The need for an advance in housing in India is so great that it will be necessary to utilise every possible agency, whether private or public. Governments should be prepared to give financial assistance in the form of loans subject to strict conditions as to repayment standards of design and construction, and the rents to be charged. Co-operative housing schemes and building societies should also be similarly encouraged and assisted.

Private building societies, whether assisted from public funds or not, should be required to set apart reserves for the maintenance of such services as refuse collection, repair of roads, cleaning of drains and similar community services for their housing estates if they are situated in areas where a local health authority does not provide such services. We have in mind the possibility of housing developments, under private auspices, outside municipal boundaries, as a result of increased transport facilities and of a desire on the part of the people to escape from the congestion of the towns into the more open surroundings of the countryside.

#### **Housing for the Lower Income Groups**

39. We believe that an India-wide housing programme should give first priority to the needs of the poorer sections of the population having less than a certain income. It is not easy to fix an upper limit of monthly income suitable for all provinces. In the South it might be Rs. 100 to 150 a month; in the North it might be Rs. 150. to 250. The limit would have to be fixed by each Provincial Government.

#### **Urban Areas**

40. In many towns and cities, industrial workers live interspersed with the general population while the proportion of such workers to the total of the community varies from town to town. In these circumstances, the housing problem must be considered for the community as a whole and not for industrial workers only, bearing in mind the income levels we have suggested for defining the working class population.

41. We believe that future developments in the housing sphere will be regulated on proper lines if such developments are undertaken under public auspices, particularly in the larger urban centres. We have already recommended the creation of improvement trusts in those large cities which are not likely to be included in the district health organisation we have proposed. These improvement trusts and, in the case of other urban centres, the local authorities concerned should undertake to provide the major part of the housing accommodation required for working class people. Such housing operations will, no doubt, have to be correlated with slum clearance and these public authorities are responsible for this activity also. The provision

of housing estates on a well-planned basis, with such amenities as water-supply, drainage, roads and lighting will also be facilitated if the public authority is in charge of such operations.

42. We have already stated that the responsibility for providing houses for the people rests upon the Governments of the country. Local authorities and industries should no doubt, bear their share of the cost, but the State cannot escape the fundamental responsibility. Where new industries are started in undeveloped areas, however, this responsibility should be squarely placed upon the organisation concerned and, indeed, as we have recommended elsewhere, it should be a condition precedent to the establishment of a new industry in an undeveloped area that adequate housing and other amenities for the labour to be employed should be provided.

### **Rural Areas**

43. The housing problem in rural areas presents special difficulties. There is not such concentrated overcrowding there as in many urban areas. The village, though often congested, with its narrow lanes and its houses huddled together, is yet surrounded by open country which is more easily accessible to the inhabitants than it is to the town dweller. On the other hand, most villages lack such sanitary services and controlled water-supply, inadequate though they may be, as exist in many of the towns. They are also without electric light, easy means of communication and many of the amenities that help to make town life more tolerable.

44. Yet, at least 87 per cent. of India's people live in the villages and their needs for better living conditions are as clamant as those of the townsmen. We believe that the minimum housing standards, which should be aimed at for the village, should be the same as those we have recommended for the lower income groups in the urban areas. There will, of course, be modifications in the lay-out and type designs of village houses which will make them more suitable for rural conditions.

45. The Governments concerned, through such local authorities as may be suitable, should be responsible for enforcing minimum standards in any new village construction. They should also assist, with finance, advice and example, in the improvement of existing houses in rural areas. Type designs for new houses and suggestions for the improvement of existing ones should be made available to the villagers through the Health and other appropriate Departments. We also suggest that the Governments should consider the desirability of arranging for the mass production of standard fittings etc., for village houses and for their sale to villagers at controlled rates, and if necessary on an instalment basis. Some of the articles suggested are door frames and doors, window frames with bars or expanded metal or wire mesh for protection, fireplaces and chimneys, wall cupboards, planks for shelves, squatting slabs for bore hole latrines, hand pumps, ventilators etc.

46. As in the case of housing in urban areas, the Governments should be prepared to finance or assist in financing any approved schemes for new housing or housing improvement, whether sponsored by the Governments themselves, by local authorities, by co-operative banks or societies or by private interests. The Governments must, however, exercise control over the planning and execution of such schemes and in particular over the rents to be charged for new houses.

and any increase into the existing rent in the case of housing improvement.

In some provinces, this may necessitate tenancy legislation to ensure that the landlord or Zamindar bears his share of the capital expenditure involved, and does not impose an undue burden on the tenant.

47. There has been some discussion in the Committee on the priority which should be accorded to housing schemes for urban areas and housing schemes for rural areas. It has been suggested that the need for housing accommodation is acuter in urban than in rural areas. It has also been suggested that, owing to the constant migration from rural to urban areas, any improvement in housing conditions in the town will reflect itself in the village. From the point of view of the health of the community, the improvement of housing and general environmental conditions in the village is as important as in the town, particularly as so large a proportion of the people of India live in the village. Conditions vary from province to province. Some provinces have highly congested industrial areas, such as Cawnpore, Calcutta, Bombay, Ahmedabad, in which there are not only slums of a type seldom seen in any other part of the world, but also acute shortage of accommodation, so that thousands are obliged to sleep, live and eat in the streets and thoroughfares of these cities. In other provinces, this problem is not so acute. We have, therefore, decided to refrain from giving any general priority to housing schemes in urban as compared with rural areas. Provincial Governments must, on the basis of the conditions prevailing within their jurisdiction, decide for themselves what are the most urgent problems from the housing point of view. All we do insist upon, is that housing should be regarded as one of India's major problems, to be attacked with all the resources which the Governments of the Country, both Provincial and Central, can mobilise.

#### **Financial Considerations**

48. The housing programme, on the scale we have envisaged, will be costly. The Governments concerned will have to abandon the policy, which most of them have followed up to the present day, of insisting that schemes for slum clearance and house construction must be self-supporting. The importance of adequate and better housing to the health and efficiency of the community cannot be calculated on a strict accounting basis. The effect of slum life, crowded tenements and ill-ventilated and insanitary conditions upon the productive capacity of the people is immeasurable. We have agreed that the provision of houses for the people is a State responsibility and that the development of housing schemes for the lower income groups, both urban and rural, should receive high priority. The State, therefore, must be prepared to provide the necessary funds by taxation or by loan.

49. There will probably be three types of schemes: those which are financed wholly from provincial or central funds; those to which the State will give grants-in-aid; and those which are financed wholly by private interests.

Where the Governments wholly finance schemes, powers may be delegated to suitable local authorities to execute such schemes subject to adequate supervision. By giving grants-in-aid or loans at low

interest rates. Governments may utilise the services of public and private agencies including building and co-operative societies. Where schemes are wholly financed by private enterprise, Government's intervention should be limited to ensuring strict compliance with all the housing and other standards prescribed by law. Many of these powers are now vested in local bodies, and provided they are effectively used and are subject to constant supervision and control by the Ministry concerned, this practice may continue.

50. It is difficult to estimate, with any precision, the cost of housing the population on the basis of the standards we have outlined above. The authors of the Bombay Plan estimated a capital cost of Rs. 2,200 crores for the construction of new houses and the reconstructing of old ones, on the basis of an average of 100 sq. ft. accommodation per head. They also estimated the cost of building a house with two rooms, a bath room, privy and a compound, with an over-all area of about 500 sq. ft. at approximately Rs. 400 in rural areas and Rs. 800 in urban areas. This may be an under-estimate at present-day costs, which are considerably higher than before the War. The cost of a house, built to the standards we have recommended, excluding the cost of land, has been estimated in one urban area at Rs. 3,000. It must be remembered that provision has to be made not only for the capital cost, but also for the annual expenditure on maintenance.

We are not in a position to express a definite opinion upon the financial implications of our recommendations. We have urged that there should be an inquiry into building costs as early as possible. Even if present costs are considerably reduced, there is little doubt that the present resources of the Governments, local authorities and private interests concerned will not be equal to the task of providing decent housing for the population for many years to come. It is possible that for a time India may have to be content with something less than the standards we have recommended in the matter of housing, etc., though we are satisfied that they are the minima desirable from the point of view of the health of the community, and should be reached as quickly as possible. The figures we have quoted should not be a discouragement but an incentive to the accomplishment of a task which is of fundamental importance to the health of the community. Most of the cost of these schemes must be met from development loans raised at low interest rates. We are confident that the public will be prepared to subscribe freely to such loans once they realise that the proceeds are to be used for an all out attack upon the deplorable housing conditions which are to be seen in the urban and rural areas of India today.

51. We will refer to paragraphs 91—99 of Mr. Kagal's report on Town and Village Planning in India which is printed as an appendix. He points out that much money has been spent on buildings constructed for war needs during the past six years. Many of them are of a temporary character and will have to be dismantled. Much of this material might well be used by municipalities, improvement trusts, and government departments, the housing schemes for the lower income groups. Every endeavour should, therefore, be made to prevent this material falling into the hands of speculative builders who might embark upon indiscriminate building schemes which in the end will only lead to slums as distressing as those which exist at present.



52. The scope for the utilisation of this war material in rural areas is possibly larger. Some of these camps, etc., which are now supplied with roads, services, and electricity might well form the nuclei for the location of new or dispersed industries, satellite towns, market places, or villages, depending upon their size and situation. The utilisation of surplus material for housing and betterment schemes is of great importance and justifies the view of Mr. Kagal that a special technical section of the department dealing with the termination of war contracts and the disposal of war materials, is necessary.



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## CHAPTER XIV

### PUBLIC HEALTH ENGINEERING

#### WATER SUPPLY

##### A Survey of the Existing Provision

1. The provision of protected water supplies was started in India in the capitals of the three major provinces of Bombay, Bengal and Madras in the latter half of the last century—in Bombay in 1856, Calcutta 1865 and Madras 1886. Although in western countries such provision began to be made at about the same time, the rate at which provision of protected water supplies in India has progressed has been much slower than in the west. According to the 1939 Report of the Public Health Commissioner with the Government of India, only 253 towns out of a total of 1,471 towns of all sizes in British India possessed protected water supplies. The population served by these water supply systems was about 12.7 millions or 48.7 per cent. of the aggregate population of all the towns, but only 4.5 per cent. of the total estimated population of British India in that year. The percentage of total population in individual provinces served by protected water supplies was small. In Madras the proportion was 6.6 per cent., in Bengal 7.3 per cent., in the United Provinces 4.1 per cent. and in the North-West Frontier Province 9.0 per cent.

2. The total capital invested on water supplies in the country during the past 80 years amounts, we are told, to less than twelve annas per head of the population and almost the whole of this has been spent in providing water to large towns.

3. Rural water supplies are mostly from wells, tanks, rivers and streams. They are very largely unprotected. Until recently the question of providing rural water supplies appears to have generally been neglected. Even now the matter is not being given the attention it deserves. During 1935—37 the Government of India gave to Provincial Governments a grant of Rs. two crores to finance rural development schemes. A part of these grants was utilised by the provinces for the improvement of water supply in the rural areas. In addition, individual provinces have spent, during recent years varying amounts from their own funds for the same purpose, but the efforts so far made are wholly inadequate to meet the requirements of the rural areas, where nearly 90 per cent. of the total population of India lives.

##### Defects of Existing Systems of Water Supply

4. Most of the piped water supplies are intermittent. The quantity provided per head of the population varies from 2 to 25 gallons a day and is generally inadequate. In some cities (*e.g.* Calcutta) there are two supply systems, one for purified and the other for unfiltered water. The former is for drinking and domestic purposes and the latter for flushing the drainage system and for street cleansing. Many supplies were designed a decade or two before execution and proved, in consequence, too small to meet the needs of the population concerned when they were completed. An augmentation of supplies has rarely been attempted in timely anticipation of possible requirements. Pressure in the distribution system is generally low

5. The standard of quality of water varies from province to province. Only a few of these maintain their own laboratories for examination of water and for plant control. Examples of such are Calcutta, Madras, Bombay and Poona. Samples from the water supplies of five of the largest towns of the United Provinces are examined by the respective municipal health officers in their laboratories. Plant control tests are, we understand, being carried out at the purification works in some cases only. In Bombay, urban water supplies have "chlorine clerks" to determine the dosage of coagulant and chlorine to be applied. With these exceptions, control over protected water supplies in the country is limited to examinations of samples once a month or once in three months by the Provincial Public Health Laboratory concerned. Such periodical examinations are, however, not sufficient to maintain a fairly uniform standard of quality throughout the year. The great majority of water-works operators are not trained in the public health aspects of the processes they carry out, and possess only mechanical skill. We noted, during our tours, that in the smaller works the superintendents have not maintained the chlorinating equipment in proper order and have not carried out tests for residual chlorine.

6. A Rural Water Supply Fund has been created in certain provinces for the improvement of rural water supplies; examples are Bengal and Madras. Bengal has spent nearly 50 lakhs in providing a large number of tube wells in rural areas to combat endemic cholera. The maintenance of these wells has been left to local bodies. We were told that more than 50 per cent. of them are functioning unsatisfactorily for want of repair while about 20 per cent. are derelict.

#### **Procedure adopted for the Establishment of Piped Water Supply Systems in Local Areas**

7. The procedure followed in the provinces for the establishment of water supply systems is generally on the following lines. If a local body desires to instal a public water supply, it approaches the Provincial Government with a request for technical and financial assistance. The latter then directs the Sanitary Engineer to investigate and frame proposals and estimates. If the local body accepts the estimates and agrees to find, from its own resources, its share of the capital cost and maintenance charges, Provincial Governments make grants-in-aid varying from 50 per cent. of the total cost to 93 per cent. The share of the local body may also in certain cases be advanced by Government as a loan. The works are carried out under the supervision of Government and are then handed over to the local body for maintenance.

8. Under such a system, the request for the provision of a protected water supply must come from the local body. Local bodies are often averse to taking the initiative. The reasons for such an attitude include the limited nature of their financial resources, absence of borrowing powers and the unpopularity that the elected representatives on these bodies will have to face when increased taxation is proposed. The passive attitude of Governments and lack of initiative on the part of local bodies have been largely responsible for the extremely slow development of water supplies in India.

9. All these facts have to be taken into consideration in putting forward proposals for the development of rural and urban water supply schemes

### **OUR PROPOSALS**

10. In order to remedy the existing state of affairs, a vigorous policy should be adopted immediately by Governments for the development of a water supply programme, which should aim at providing the entire population under their charge with safe water for drinking and domestic purposes within a period of about 35 years. The initiation of schemes should not be left to local authorities and sufficient funds should be made available to complete the programme within this period. We consider it necessary that technical bodies, which will be able to plan water and drainage schemes on a comprehensive scale and assist in the solution of problems associated with them, should be established both at the Centre and in the Provinces. We shall now describe these organisations, their proposed constitution and functions.

#### **Central and Provincial Water and Drainage Boards**

11. For the reasons indicated below, we consider that the proposed organisations at the Centre and in the Provinces should deal simultaneously with the planning of water supply and drainage schemes for individual areas where they are to be introduced and it is for this reason that we term them Central and Provincial Water and Drainage Boards.

12. The provision of a piped water supply should simultaneously be accompanied by arrangements for drainage. Otherwise, conditions resulting from the presence of stagnant water, such as the breeding of mosquitoes, are bound to arise. In the case of the larger towns and cities, a proper sewerage system would be financially possible. Such a system would make provision for the proper disposal of nightsoil and for the removal of storm water from the inhabited areas. In smaller towns and villages a sewerage system may not be feasible for financial and other reasons. It will be remembered that we have already recommended in the previous chapter that, for such towns and rural areas, the disposal of nightsoil should be arranged, as far as possible, by providing septic tanks and soil distribution systems for the effluent from these tanks. In the circumstances, surface drains, properly constructed and maintained, will constitute perhaps the best method of dealing with surface water in such places. The provision of these drains should be considered as an essential accompaniment of the establishment of a piped water supply system and should not be delayed on any account.

#### **Functions of the Boards, Central and Provincial**

13. The functions we suggest for these Boards are described in detail in Appendix 25. The Central Board will perform the dual task of carrying out, in the Centrally Administered areas, the same duties which a Provincial Board will perform in its own territory as well as of dealing with various matters of interest and importance to more than one province, such as the conservation of water on an All-India basis and inter-provincial problems of drainage and river pollution. In addition, the Central Board will assist the Central Government in carrying out, in the fields of water supply and drainage, its general

policy of promoting co-ordination of effort in the provinces and of giving financial aid and technical advice in the furtherance of their schemes

### **Common Functions of the Central and Provincial Boards and provision for their performance.**

14. The more important among the common functions to be performed by the Central and Provincial Boards in their respective areas include the following:—

(1) the conservation of the available sources of water, in their respective areas, and its allocation to the different needs of the community, including drinking and domestic purposes, industrial needs and the requirements of hydro-electric development;

(2) the general planning of water supply and drainage schemes and the preparation of a list of priority in respect of such schemes;

(3) various technical subjects such as (a) the standards to be prescribed for the purification of water and sewage, (b) the standards to be aimed at in the maintenance of water works, urban and rural, as regards mechanical equipment and plant control, (c) the training and registration of water operators and (d) investigation of special local problems such as the purification of trade waste, removal of fluorides etc. and

(4) the recommending of grants-in-aid, to the Governments concerned, for water and drainage schemes.

15. Some of the subjects included here cover the fields of activity of more than one Department of Government and decisions taken in respect of them may have wide repercussions on the life of the community. Such decisions will therefore have to be taken by Government after due consideration of all the relevant factors. It will be the responsibility of the Boards to place before the Governments concerned such technical information as will prove useful to the latter in determining the course of action to be followed. The functions of the Boards will therefore be mainly advisory.

### **Provision of Laboratory Facilities for the Boards**

16. In order to carry out the planning of schemes, each Board will have to employ a technical staff competent to undertake the necessary preliminary investigations, to prepare a detailed programme of works and to estimate their cost. The technical questions it may be called upon to solve will require the services of a laboratory equipped and manned suitably to deal with the investigation of such problems. Therefore, in these specific spheres, the Board will become responsible for certain executive functions also.

17. As regards the provision of such laboratories at the Centre and in the Provinces, it is presumed that in the investigation of many of these problems, existing public health laboratories will be able to participate if suitable additions to staff and equipment are made available. Where the engineering aspects of such problems have to be investigated engineering colleges can, it is believed, be brought in to help. We consider that, in the interests of economy, it is desirable to explore all possibilities of co-ordinating existing research facilities and of improving them, provided the required standards of efficiency can be attained. In the early stages of our development programme

any saving that can be effected in trained personnel and in funds will help materially to facilitate the expansion of the scheme.

#### **Allocation of duties in respect of Water Supply and Drainage between the Board and certain Government Departments**

18. The main administrative duties in respect of water and drainage will, in our view, continue to be discharged by the Public Works Department of Government and the Public Health Engineering Section of the Health Department, Central and Provincial. The former will be concerned with the construction and maintenance of water works and drainage, while the latter will be responsible for the supervision necessary to ensure compliance with prescribed standards. Where Provincial Governments maintain a special department for dealing with drainage and water works we do not desire to suggest any change in their arrangements. The Water and Drainage Board, Provincial or Central as the case may be, will undertake, in its capacity as an expert body, the functions of long-term planning, of prescription of standards and of investigation of the problems associated with its own duties or of special ones referred to it for advice. The work of each of these two organisations will thus be complementary to each other.

#### **Certain Special Duties of the Central Board.**

19. We have already indicated the special duties which the Central Board should perform in addition to those which it will carry out in the Centrally Administered Areas on the same lines as those which the Provincial Boards will discharge. Of these special duties, we desire to deal here with (1) the conservation of water in order to meet the needs of the different provinces concerned and (2) inter-provincial problems of drainage and river pollution.

#### **The Need for Water Conservation on an Inter-provincial Basis**

20. We may, at this stage, draw special attention to the imperative need for considering the question of conservation of water on an inter-provincial basis and of its equitable distribution for the different needs of the community. The importance of this question was forcibly brought to our notice by the Superintending Engineer, Public Health Engineering Department, the United Provinces. In a memorandum which he submitted he stated that "the depletion of the main rivers in this Province, particularly in the Jumna and the Ganges by the wholesale extraction of large quantities of water by the Irrigation Departments of the Punjab and the United Provinces, has had very serious repercussions on the water supply to several large towns in this Province, particularly Agra and Cawnpore. It has also created another problem which has to be solved, that is, large scale river pollution. Most of the large towns in the United Provinces are located on the banks of rivers and with the limited flow in the summer months there is now, not sufficient dilution to permit of the discharge of untreated or partially treated sewage into the rivers as formerly was the case on the downstream side of the towns. Towns like Cawnpore and Agra will therefore for this reason be compelled to spend large sums of money on the construction of artificial sewage purification works to produce an effluent of a high standard. This huge expenditure, which in the case of Cawnpore will be at least Rs. 25,00,000 and a proportionate amount at Agra, which is also confronted with the same problem, would not have

been necessary, as a much lower standard of purification would have sufficed if the normal flow in the rivers had not been interfered with by the extraction of huge quantities of water for distribution on areas for cultivation miles away from the headworks, none of the water extracted being returned in any form whatsoever to its original source." As regards water for drinking and domestic purposes it was pointed out, that "at Agra due to the absolute negligible flow in the river in summer months, the Municipality has to dig channels in the river bed to lead what virtually is a trickle of water to the intake of the waterworks pumps to afford a very limited supply of potable water to the town." Similarly at Cawnpore it is reported that, in the summer months, extensive dredging operations are necessary "to get sufficient river water to the intake of the waterworks pumps."

21. The question of conserving all the available sources of water throughout the country and of so allocating the supply, from a common source, as to meet the reasonable demands of the individual provinces concerned, is of paramount importance from the standpoint of the health and general welfare of the people and we have come to the conclusion that this matter calls for special consideration. Where an urgent decision in such matters is required, the Central Government should be empowered to give a temporary decision, which should be binding on the provinces concerned until a final settlement is reached through the award of an Arbitration Board or any other suitable body, to which reference should be made with the least practicable delay.

#### **Inter-provincial Drainage and River Pollution Problems**

The same procedure should apply to inter-provincial problems of river pollution by trade-waste and sewage.

22. Even in a case where an emergent decision has to be given by the Central Government we consider it necessary that such decision should be taken only after consulting the Central Water and Drainage Board and the Central Board of Health in regard to the technical and administrative aspects of the question.

One of us (Mr. P. N. Saprú) does not agree with the above recommendations for dealing with these difficult problems. He has set out his views in a note which is appended to this chapter. The rest of us, while recognising that provision already exists in sections 130-134 of the Government of India Act, 1935, for securing redress in respect of executive action or legislation affecting prejudicially any natural source of water supply in a Province or a Federated State, consider it necessary to provide machinery which will facilitate speedy action in particular cases as well as help to solve the larger problem of conserving the available sources of water in the country as a whole and of so allocating the supply, from a common source, as to meet the reasonable demands of individual provinces. These provisions of the Government of India Act, which have been in operation since 1937, have not so far helped to solve or even alleviate the serious situation in Agra and Cawnpore, to which we have referred. In our view this state of affairs has been reached because of the absence of a competent body to review, from time to time, the problems of water conservation and river pollution on an inter-provincial basis. The Central Water and Drainage Board we have proposed is intended to

fulfil this role and the composition suggested for it in the next paragraph should help to ensure the technical competence of the Board to consider such problems. The Board will act only in an advisory capacity and its recommendations will be subject to review by the Central Board of Health consisting of the Ministers of Health at the Centre and in the Provinces. Therefore, even in giving an *interim* decision, the Central Government will be in possession of the views of a body, whose composition should help to ensure the consideration of such questions not in the interests of individual provinces but of the country as a whole. We may also point out that the procedure we have suggested for the settlement of disputes is more likely to provide, in view of the authorities concerned being within India, speedier decisions on such disputes than the existing procedure under sections 130-134 of the Government of India Act, to which our colleague refers.

### Composition of the Boards

23. We recommend that the Central and Provincial Boards should include suitable persons from among representatives of the following interests:—

- (1) the Agricultural, Irrigation and Hydro-electric Departments of Governments;
- (2) the Public Health Engineer attached to the Central or Provincial Health Department as the case may be;
- (3) the waterworks engineer and drainage engineer respectively of two large cities possessing piped water supply and sewerage systems;
- (4) a microbiologist of standing from a research institute or a university;
- (5) a distinguished worker in the field of water and sewage analysis;
- (6) a geologist;
- (7) the officer in charge of the Central or Provincial malaria organisation as the case may be;
- (8) the Director General or the Provincial Director of Health Services;
- (9) the Chief Engineer of the Central or Provincial Public Works Department;
- (10) the Secretary of the Ministry of Health, Central or Provincial and
- (11) representatives of local authorities in the case of Provincial Boards and of the local administrations in the case of the Central Board.

### The Planning of a Provincial Water Supply Programme

24. We may now consider, in greater detail, the planning of a water supply programme. It is essential that the inclusion of intermittent and dual water-supply systems, which exist in India today, but which are recognised as a danger to the public health in other countries, should not be permitted in our programme for the future. We are indebted to Mr. K. Subrahmanyam, Professor of Public Health Engineering, All-India Institute of Hygiene and Public Health, for most of the details on which the following plan for the province of Bengal has been prepared. It is no more than a suggestion as a rough guide not only to Bengal but to other parts of India.



25. The following assumptions are made as the basis of a reasonably progressive plan, provided sufficient funds are available:—

- (1) 50 per cent. of the population should be provided with safe water during the first 20 years of the programme and
- (2) during the next 15 years the scheme should be extended to cover the remaining 50 per cent.

26. The water supplies to be provided may be of two types. For the smaller villages with populations under 1,000 we recommend wells properly constructed so as to prevent surface and subsoil contamination and with pumps installed. On the assumption that one such well can serve about 250 persons, Mr. Subrahmanyam considers that the average cost in Bengal will be about Re. 1 per head of the population. In villages with populations of 1,000 and over it is suggested that a piped stand-post water supply system should be introduced. The cost of such a system will, he considers, range between Rs. 10 and 15 per head of the population in that province. It is recognised that the cost will vary considerably from province to province. It is desirable that, for each village, a source large enough to supply water at 25 to 30 gallons per head of the population should be investigated and located. The source must be as close to the village as possible. Pumps and elevated tanks may be designed, if necessary, on the basis of a stand-post supply of 8 to 10 gallons per head, but the distribution mains should be such as to provide for house connections and for an ultimate consumption of 25 to 30 gallons per head per day. In the beginning there need be provision only for street stand-posts at the rate of, say, one for 80 to 100 users or one at every 150 yards. There should be provision for sterilisation of the water supply. The introduction of such water-supply systems of particular importance in the control of cholera, and priority in the planning and execution of water works should be given to those areas which are recognised endemic centres of the disease.

27. Mr. Subrahmanyam has estimated that, for the development of a water supply scheme on the lines indicated above, the annual expenditure for the first 20 years will be, for Bengal, about rupees two crores. According to him this figure will include provision for the purification of water and maintenance charges including repairs and renewals. The corresponding figure for India as a whole, he estimates, will be about Rs. 12 crores to Rs. 14 crores per annum.

28. It should be noted that these estimates are based on pre-war costs and will therefore require revision to suit conditions in regard to costs prevailing at the time of construction.

### **Priority in the Provision of Water Supply**

29. The preliminary task of the Provincial Water Boards will be to draw up a plan of action. Certain general principles should be laid down for determining priority in respect of provision of water supply in specified areas and we suggest the following:—

- (1) the incidence of cholera and other bowel diseases;
- (2) the importance of the place as a centre for fairs and festivals;
- (3) its location in relation to important lines of communication and
- (4) the difficulty in obtaining water during the hot weather.

80. When the local people are willing to contribute either in cash, labour or material towards the construction of such works it is for consideration whether this should not constitute some claim for priority. We believe that the development of the spirit of self-help in the provision of amenities should be stimulated as much as possible

#### **Minute on Water Supply by The Hon'ble Mr. P. N. Saprú.**

My colleagues observe: "The question of conserving all the available sources of water throughout the country and of so allocating the supply, from a common source, as to meet the reasonable demands of the individual provinces concerned, is of such paramount importance from the stand-point of the health and general welfare of the people that we have come to the conclusion that this matter calls for special provision. Where an urgent decision in such matters is required, the Central Government should be empowered to give a temporary decision, which should be binding on the provinces concerned until a final settlement is reached through the award of an Arbitration Board or any other suitable body, to which reference should be made with the least practicable delay." I am unable to agree to this recommendation as the procedure suggested involves the giving of an *interim* decision by the Central Government which might ultimately prejudice an impartial decision by the Arbitration Board and which, if upset, would place the Central Government in an embarrassing situation and lay it open, should the ultimate award be different from that decided upon as an *interim* solution, to the charge of being partial.

The question of *complaints* as to interference with water supplies on the part of any Governor's province or the ruler of any federated state was considered by the Joint Select Committee on Indian Constitutional Reform and is regulated by Sections 130, 131, 132, 133 and 134 of the Government of India Act. The question of canals was specifically referred to by the Attorney-General. The White Paper had suggested that the provinces should be given exclusive legislative power in relation to "water supplies, irrigation and canals, drainage and embankments, water storage and water power" and had reserved no powers of any kind to the Federal Government or the Federal Legislature. Even under the scheme as envisaged by the White Paper, the Federal Court would have had jurisdiction to decide any dispute between the two provinces in connection with water supplies; if legal rights or interests were concerned; 'but the experience of most countries', so the Joint Select Committee explains, 'has shown that rules of law based upon the analogy of private proprietary interests in water do not afford a satisfactory basis for settling disputes between provinces or states where the interests of the public at large in the proper use of water supplies are involved.' They further pointed out that they were cognisant of the importance from the public point of view of the distribution of water in India, upon which not only the prosperity but the economic existence of large tracts depends. They however came to the conclusion that it was neither desirable nor feasible to make the control of water supplies a wholly Federal subject. Yet, this is, apparently what my colleagues, without giving any adequate reasons for their dissent from the Joint Select Committee's recommendations, suggest. The

Joint Select Committee suggested, and the suggestion has been incorporated in the Government of India Act that "where a dispute arises between two units of the Federation with respect to an alleged use by one unit of its executive or legislative powers in relation to water supplies, in a manner detrimental to the interests of the other, the aggrieved unit should be entitled to an appeal to the Governor-General acting in his discretion, and that the Governor-General should be empowered to adjudicate on the application". 'We think, however,' they went on to observe, 'that the Governor-General, unless he thinks fit summarily to reject the application, should be required to appoint an Advisory Tribunal for the purpose of investigating and reporting upon the complaint. The Tribunal would be appointed *ad hoc*, and would be an expert body whose functions would be to furnish the Governor-General with such technical information as he might require for the purposes of his decision and to make recommendations to him. Naturally, the recommendations of a tribunal like this would carry weight with the Governor-General but they would not be binding on him.' The definite recommendation that the Joint Select Committee made was 'that provision should be made for excluding the jurisdiction of the Federal Court in the case of any dispute which could be referred to the Governor-General in the manner which we have suggested'. They particularly stressed that the powers of the Governor-General should not extend to a case where one unit is desirous of securing the right to make use of water supplies in the territory of another unit, but only to the case of one unit using water to the detriment of another.

In the debate that took place in the House of Commons (30. Parl. Debates, Indian Affairs, Commons, 1934-35, Vol. II, Col. 2437) the Attorney-General explained that Section 130 was intended to provide a method of settling rights, in natural sources, which cannot be taken to a court of law because there are no legal principles by which the courts can regulate any disputes which may arise. It is for this reason that canals had not been put into the Clause because they can be disposed of by ordinary tribunals and do not require to be referred to the special tribunals which are set up.

No reasons have been advanced for going beyond what the Joint Select Committee and Parliament considered was necessary in the interests of protecting the rights of water being used to the detriment of a province. Under a system of complete responsible government the Governor-General would not be able to act in his discretion. It is for the constitution-makers of the future to devise a machinery, if they so think fit, which would vest the power of investigating complaints in an authority representative of both the provinces and the Centre. But I do definitely think that no case, supported by any overwhelmingly large expert evidence, has been made for recommending that the powers which the Provincial Governments enjoy in the matter of water supplies should be whittled down. Inter-provincial problems of river pollution by trade waste and sewage, to which reference has been made in the body of our report, are capable of solution on the lines of the procedure laid down in section 103 of the Government of India Act. Consistently with the view that I hold that the autonomy envisaged by the Government of India Act should not be whittled down, I am unable to support the recommendation of my colleagues that the Centre should have the power to

arbitrate and give a decision which would be binding on the provincial authorities concerned in inter-provincial problems of river pollution, by trade waste and sewage. If the provinces think that river pollution is a problem which requires urgent action, they or such of them as feel the urgency of the problem, can transfer authority to the Central Legislature under the procedure laid down in Section 103 of the Government of India Act, 1935. I may state here that I must not be understood to agree to any proposal, in any part of the report, which will have the effect of giving a greater central bias to the constitution than that which is envisaged by the Government of India Act of 1935. In fact, I may add that I am opposed to sub-section (4) of Section 126 of the Government of India Act, which was passed as an emergency war measure.

## **GENERAL SANITATION—CONSERVANCY AND DRAINAGE**

### **A Survey of the Present Position**

1. The present position in respect of sanitation is, speaking generally, highly unsatisfactory in both rural and urban areas. Practically no provision exists in the smaller villages for the collection and disposal of excreta and refuse and houses in such villages rarely have latrines. Very limited efforts have been made in a few small towns, panchayats and union boards to promote conservancy services, but here also the level of sanitation generally is low and, in these places too, most houses are not provided with latrines. A scavenging service and trenching are the usual methods of collection and disposal of nightsoil for such communities.

2. Sewerage has been provided only in a very limited number of the larger towns and cities and the inhabitants of these form only about 2 per cent. of the total population of the country. The underground drainage system was first introduced in India in Calcutta in 1870, about 20 years after its provision in London and 18 years after its establishment in New York. The extension of the sewerage system in India has, however, been extremely slow as compared with western countries.

3. Refuse disposal is generally carried out by dumping in low lying areas. Very few cities practise incineration as a method of its disposal.

### **OUR PROPOSALS**

4. An improvement of the general sanitation in the inhabited areas of cities, towns and villages is a matter of urgent importance from the point of view of controlling a large part of the preventable ill-health. Nevertheless, the difficulties in the way of promoting a rapid advance in this field of health administration are so great that we feel the ingenuity and resources of Governments will be taxed to the utmost extent in solving these problems. The question of providing adequate funds stands out, of course, as one of the major difficulties. There are others, including the creation and maintenance of well-manned and equipped technical organisations to deal efficiently with the problems of environmental hygiene and the education of the people with a view to their accepting and practising the hygienic mode of life.

5. One difficulty that exists at present is that the self-governing units are, in many cases, so small (e.g., union boards and panchayats) that it is quite impossible for them to organise and maintain satisfactory conservancy services for the populations entrusted to their care. This remark applies in a greater or less degree to most municipalities including some of the larger ones, where the rates imposed are not adequate and are not properly collected. We have suggested, in Chapter XVII of this volume of the report, the abolition of the many small local authorities that now exist in individual districts and their replacement by a single body, the District Health Board, to control the whole area with the exception of the territory covered by certain large municipalities with populations of 200,000 and over. This proposal of ours should help to pool the resources of most of the existing local bodies in a district but we are doubtful whether, without developing other sources of revenue than those which these local administrations have at present, sufficient funds for the improvement of general sanitation and for the development of other health activities will become available. This is a matter which should receive urgent and serious consideration but, in view of the complex questions the subject of public finance raises, we feel that we must leave it to Governments to investigate.

#### **Collection and Disposal of Excreta**

6. In the section dealing with housing we have already expressed our view that the manual handling of nightsoil during its collection and disposal should be rendered unnecessary as far as possible. For this purpose we favour the introduction of the water-carriage system as widely as may be practicable. We realise, however, that the provision of this amenity even in urban centres with populations of 50,000 and over will require an outlay of some 60 crores of rupees on capital works and recurring charges on an adequate technical organisation for their maintenance. In view, however, of the importance of providing for the proper sanitation of at least the more congested urban areas we recommend that the sewerage of all towns with a population of 50,000 and over be made an objective to be attained within the short-term programme of the first ten years.

7. For smaller places, urban and rural, we recommend the use of septic tanks and soil absorption systems in order to extend the advantages of water-borne conservancy over as wide an area as possible. We recommended, in the section dealing with housing, that the provision of such septic tank latrines should be enforced on all owners who can afford the cost of their construction, and have also suggested that measures other than legal enforcement should be adopted in order to popularise and extend its use. Cheap and effective type plans have already been evolved, after experiments, by health authorities in certain parts of the country. Squatting plates made of porcelain or concrete with a water seal, which requires only a comparatively small quantity of water for flushing, have been made. Experiments in this direction should be continued as well as on the evolution of suitable types of efficient and cheap septic tanks. We suggest that provincial authorities should promote the construction of suitable squatting plates and make them available at cost price or less to the public.

8. In all unsewered areas we recommend that, for public latrines, the septic tank type should be employed wherever possible. In

every case the effluent from the septic tank should be distributed in the subsoil to a reasonable distance before it is permitted to drain into any water course. The local health authority should exercise control over the establishment and functioning of this type of latrines. We recommend, therefore, that their construction for private use should be governed by suitable conditions to be laid down and enforced by such authorities. In the areas under our scheme the exercise of the proposed control should present no great difficulty because the public health engineering section of the health staff will provide the required technical personnel for such supervision. In the areas outside our scheme, the existing health organisations should also exercise similar control as far as possible. In both types of areas the distribution to the people of type designs which utilise, as far as possible, local material and are cheap to construct should go a long way to popularise this kind of latrine.

9. In many places, where soil conditions are suitable, bore-hole latrines can be brought into use if a cheaper type than the septic tank latrine is required. In the Province of Madras, where the health authorities have had considerable experience of bore-hole latrines, we were told that this type, while it is satisfactory for individual houses, has not been found equally so for public use. We recommend, therefore, that, for the latter, the septic tank variety of latrine be preferred.

10. The squatting plates we have suggested for septic tank latrines can also be used for the bore-hole type and we recommend that provincial authorities should make these available at cost price or less so as to popularise their use.

11. For the area under our scheme we recommend a vigorous policy of latrine construction. The Public Health Inspector should be in charge of this work. One of the duties of the squad of fifteen labourers, provided in our scheme, will be to demonstrate to the villagers how to instal bore-hole latrines. Latrine augers and all other appliances that may be required should form a part of the equipment of the staff. Apart from propaganda some form of inducement may often be necessary to persuade the villagers to provide themselves with latrines. One of the methods tried in certain districts of Madras was to give to every householder who put up a latrine, a squatting plate at half the cost price or even free. A bore-hole latrine used by a single family should last for about 2½ to 3 years and should not cost more than about Rs. 15 including the squatting plate.

12. The progress made in the construction of these latrines will depend largely on the support that the public health staff of the primary unit can secure among the people. If each of the two public health inspectors in a primary unit could secure the construction of about 80 latrines in his area per month, about 7,200 such latrines would have been provided during the short-term programme in each unit. A rough estimate of the total number of houses in a primary unit with an average population of 40,000 is 8,000. The rate of construction suggested above will, therefore, largely solve the problem of nightsoil conservancy and the effect of this one measure alone on the health of the community would be considerable.

13. In connection with bore-hole latrines, it will be necessary to organise a re-boring service. Otherwise, with the filling up of the latrines in about two or three years, the people may revert to their previous habits.

14. The location and building of public latrines will, of course, be under the direction of the local health authority. The provision of water for ablution is desirable as apart from other considerations, such water helps the digestion of nightsoil in the bore-hole latrine.

15. We recommend that all schools, students' hostels, public offices, jails, and halting places for travellers such as dharmasalas, should be provided with septic tank latrines. The urinals for these institutions should also be connected with such latrines. These proposals should first be enforced in the areas under our scheme and may later be gradually extended to other places.

16. With regard to the disposal of excreta in unsewered towns, the existing practice is mostly to trench it. The sites for the trenches are unsatisfactory in some cases and the amount of supervision exercised over trenching operations is not sufficient to ensure their being conducted efficiently. We are of opinion that greater attention should be paid to these matters till the more efficient methods of nightsoil conservancy we have already indicated can be universally applied.

17. In some towns the nightsoil is mixed with refuse and a compost is made. This is a good way of "converting waste into wealth", but the process has disadvantages of which the handling of nightsoil is perhaps the greatest. Another is that it may promote fly-breeding unless adequate precautions are taken. These include the carrying out of composting in masonry trenches or on masonry platforms and under a roof in those areas where the monsoon rains are heavy. On the whole, after weighing carefully the hazard to health against the gain in manure, we are inclined to discourage composting unless the handling of nightsoil can be prevented and other necessary precautions can be taken. We would, however, advocate composting as an excellent method of disposal of the dung of cattle and other animals.

#### **Refuse Collection and Disposal**

18. In the rural areas the public health inspector should encourage the construction of manure pits in houses outside the inhabited area. In certain parts of the country, where people might not have land of their own, a common manure pit should be provided. The village committee, we have proposed, should see to the provision of such common pits and their proper use. Villagers with cattle should be induced and trained by the health staff to compost cattle dung.

19. The systematic sweeping of all public places and the collection of refuse should be organised in the larger villages such as those which now have panchayats and union boards. All municipalities should insist on the owners of houses providing dust bins of an approved pattern and should undertake the collection of refuse from such bins. Standard dust bins of a durable type with bottom and cover lid must be used. The collection and disposal of refuse by contractors are undesirable, as it is difficult to ensure satisfactory service.

20. In the Municipal Acts provision generally exists for the levying of a scavenging tax to cover the cost of the service. Where this provision does not exist, the necessary steps should be taken to provide such powers.

21. It is recommended that municipalities with a population of 50,000 and over should maintain municipal workshops for repairs to the vehicles used for refuse collection.

22. The method of disposal of refuse adopted in a particular municipality will depend on local conditions. Whatever be the method that is used, it should be such as to ensure that fly-breeding and other hazards to health are prevented.

23. The disposal of rubbish by incinerators is recommended for all cities of 100,000 population and over. The construction and use of incinerators should also be encouraged for hospitals and other large institutions.

### **The Collection and Disposal of Sewage and Industrial Waste**

24. As has already been pointed out, when a community is supplied liberally with water, the disposal of the used water becomes an important problem. Hence sewage works and drains have to be planned and built to keep pace with the extension of piped water supplies, particularly in the larger urban centres.

25. The short-term objective we put forward is the planning and the carrying out of sewerage and sewage disposal works in all towns with populations of 50,000 or more and, in all health resorts and industrial colonies housing 1,000 people or more as well as the remodelling of existing sewerage systems on lines sufficient to provide for the connection of at least 95 per cent. of the houses in the areas concerned. This will bring the benefits of the water-borne system to approximately 50 per cent. of the urban population, including under this class all towns with populations of 5,000 and over.

26. We have provided for the short-term programme of sewerage construction a sum of Rs. 60 crores in all, or Rs. 6 crores per annum for 10 years for British India alone. It is suggested that one half of this amount may be given as grants and the other half as loans to local bodies. As in the case of water supply, the initiative for the development of the programme must come from the Provincial Government and the Provincial Drainage and Water Board. The latter should, through its technical staff, prepare plans and estimates for sewerage all towns of 50,000 population and over, and Provincial Governments should, in co-operation with local authorities, carry out these plans as quickly as circumstances permit. The ultimate aim should be to extend sewerage systems to all urban communities. In the meantime the provision of open drains, properly constructed and maintained, will be necessary for towns with populations of less than 50,000 because the introduction of a piped water supply should be accompanied by adequate provision for drainage. The Provincial Water and Drainage Board should be responsible for the planning of this type of drainage also.

27. We have not dealt with the disposal of industrial wastes separately. We think that they may, in many cases, be let into the city sewers in places where these exist. Certain trade wastes will, however, require prior treatment before they are permitted entry into the sewers, because such wastes may interfere with the biological action which is the basis of sewage disposal. These wastes must therefore receive such treatment as may be necessary before they are



permitted to leave the premises of the factories concerned. If factories are located far away from the sewered area of a town or in a place where the underground drainage system does not exist, the need for adequate treatment of the waste water will, in many cases, be even greater.

28. Both sewage and trade waste, when they emerge after appropriate treatment, should have attained certain standards of purity before they can be permitted to flow into rivers, lakes, the sea and other large bodies of water. Water and Drainage Boards will be responsible for supplying Governments with suitable technical advice in respect of such problems. This subject is dealt with more fully in the next section dealing with river and beach pollution.

## RIVER AND BEACH POLLUTION

### Introduction

1. The uncontrolled discharge of sewerage effluents and industrial wastes into bodies of water such as tanks, lakes, streams and the sea produces conditions which are offensive to sight and smell, endanger public health, kill fish life and change the natural flora and fauna. It may produce other detrimental effects such as the loss of certain recreational facilities to the community and a depreciation of the value of property situated close to these polluted tanks, lakes and other water collections. It is, therefore, clear that such pollution should be controlled in the public interest. The quantity and strength of the sewerage effluent admitted to natural water sources should be adjusted with due regard to the volume and capacity for oxygenation and self-purification of the receiving bodies of water as well as to the uses to which these will normally be put by the community. The extent to which public water supplies derived from rivers and streams, which are liable to a sewerage pollution, have to be purified depends on the load of such pollution.

### Existing Conditions

2. In India there are many towns and cities on the banks of rivers. Only a few cities are sewered and industries have not yet developed on a scale comparable with the more advanced countries of Europe and America. Hence it may appear that the problems of river and beach pollution are not so grave here as in those countries. This is, however, only partially correct. Whether sewered or not, most of the big cities are situated on the banks of rivers or on the sea coast. The general sanitation of many of these cities is of a low standard and a varying proportion of the sillage and nightsoil from them finds its way to the rivers and the sea. Examples are the Gumti which is polluted by the sewage of Lucknow, the Ganges by the sewage of Cawnpore and of Benares and the Jumna by the sillage of Agra and the sewage of Allahabad. The Hooghly receives discharges of wastes from the factories and of sillage from the towns, which are situated on both sides above and below Calcutta. The situation became so acute in the Calcutta area that legislation was enacted requiring that sewage effluents into the Hooghly should be sterilised. It is understood however, that the law has, in practice, been rarely enforced. The discharging of effluents from sugar mills, distilleries, paper mills, tanneries and other industries into rivers and ponds has given rise to offensive conditions in various parts of the country. The problem is likely to become more acute with the anticipated post-war growth in

urbanisation, in industrialisation and in the sewerage of urban areas, unless adequate measures are undertaken without delay.

### **Control in England and the United States**

3. In England pollution of rivers by sewage was one of the subjects considered in the report of the Royal Commission on sewage disposal in England. The rivers in that country have been stated by one authority to be too short to undergo any appreciable self-purification. The Royal Commission recommended certain standards for sewage effluents depending on the extent of the dilution to which it is subjected. These standards have been found to be suitable on the whole. In that country the control of a river basin or catchment area as a whole is entrusted to an organisation known as a River Board.

4. In America the laws and practices for the control of river pollution vary in different States. In some the rivers are divided into classes according to their natural uses and standards of purity for effluents are prescribed according to the class of the river concerned.

### **OUR PROPOSALS**

5. In our view early action is essential in order to prevent this problem reaching an acute stage in India. Existing laws provide, to some extent, for action against the fouling of water supplies. For instance, the Indian Penal Code makes the voluntary corrupting or fouling of the water of a public spring or reservoir a penal offence. While some Provincial Local Self-Government Acts, by placing the control of streams, channels, and other water sources not situated on private property, under local bodies, have made it possible for the latter, if they are so disposed, to control pollution by sewage and trade waste. But these legal provisions have so far had little practical effect as they have not been enforced. Further, the problems of river and beach pollution are often of such magnitude that uncoordinated efforts by individual local bodies or by the police in respect of the provisions under the Indian Penal Code, are not sufficient to meet the situation.

6. In the sections dealing with water supply and general sanitation we have recommended the establishment of Central and Provincial Water and Drainage Boards and have included among their functions the control of river and beach pollution. We attach considerable importance to this recommendation. These boards, acting in close co-operation, will be in a position to deal with a river basin or a catchment area as one organic unit and to view the problems of developing water supplies and of sewage disposal in such a manner as to harmonise conflicting interests and to ensure the safeguarding of the public health. On their advice the Central and Provincial Governments will, in consultation, be in a position to take appropriate action to control river pollution on an inter-provincial basis as well as to deal with beach pollution.

7. On the technical advice tendered by the Boards, Governments should make legal provision requiring the fulfilment of certain standards of purity for sewage effluents and for trade wastes if they are to be permitted to flow into rivers, seas, lakes, and other sources of water. Complicated questions that may arise in respect of the treatment of special types of trade waste can be investigated by the Boards through their technical staff and laboratories.

## CONTROL OF INSECTS, RODENTS AND OTHER VECTORS OF DISEASE

### Introduction

1. Control of the environment so as to make it unsuitable for the breeding of certain insects, rodents and other forms of animal life which transmit disease to man is also a function of a modern public health engineering department.

### Mosquito Control

2. We have dealt with mosquito control in the section on malaria. Preventive measures such as surface and subsoil drainage, the flushing of rivers and other water courses and the shading of breeding places should be undertaken only after a careful study of the habits of the type or types of mosquitoes responsible for transmission locally. We recommend that such schemes should be carried out under the combined technical guidance of the malarialogist, the public health engineer and the entomologist.

3. Other recommendations, which we have included in that section, are (1) the acquirement, by local health authorities, of the necessary legal powers for the enforcement of anti-mosquito measures and (2) the requirement that, in respect of all construction works undertaken by the different departments of Government, the Ministry of Health should be consulted and that all antimalaria measures prescribed by that Ministry should be carried out. The cost should be included in the estimates for these projects and the health authorities should be entrusted with their execution.

4. We recommend that mosquito control should be exercised to the highest possible degree in and around aerodromes and major sea ports in order to prevent the introduction of yellow fever into the country.

### Rat Control

5. We have dealt with this question, at some length, in the section on plague, and do not, therefore, propose to cover the same ground here. We may, however, state our view that a permanent solution of the rat problem will be secured only through the ratproofing of dwellings and stores for grain and other articles which provide food attractive to rats. While recognising that this is a very costly measure, we feel we are justified in asking that it should be accepted as a long-term objective in order to secure lasting benefits to the country. Apart from the effective control of plague that ratproofing will bring about, the economic gain to the community will be considerable. Various estimates of the loss caused by rats have been made. A conservative estimate of the annual loss to the country from this source places the figure in the neighbourhood of Rs. 800 crores, a sum which would more than suffice to finance our entire health programme for the first ten years.

6. Ratproofing should, in the first instance, be carried out as far as possible in the endemic centres of plague and should later be extended all over the country.

7. While the carrying out of this suggestion must necessarily be spread over a comparatively long period of years, we would suggest

that the seasonal measures for rat control, which we have recommended in the section on plague, should be carried out in order to keep down the growth of the rat population.

### **Fly Control**

8. The domestic fly will continue to be a menace to the public health until the level of general sanitation in towns and in the countryside improves considerably. The satisfactory collection and disposal of the dung of animals and of other refuse are essential to produce the desired improvement. We have already dealt with the question of general sanitation and shall not, therefore, repeat here the steps that we suggest should be taken.

9. The danger from the fly as a carrier of disease will decrease in proportion to the extent that the programme of nightsoil conservancy through an extension of the water carriage system and through the construction of latrines, which we have advocated elsewhere in this report, becomes implemented.

10. The control exercised by most municipalities in India over the manufacture and sale of articles of food, including dairy products, and over the sanitation of stables and cattle yards is quite ineffective. These local bodies have, under their self-government Acts, adequate powers to exercise the necessary control. Their neglect of this duty is, in a large measure, responsible for fly-breeding and for the dissemination of diseases carried by flies in the areas under their charge. We hope that the proposals we have set out in Chapter XVII for improving the standard of local health administration will, if carried out, help to remedy to a large extent the existing state of affairs.

11. There is evidence from England and America that the replacement of animal driven vehicles by motor transport has contributed to a remarkable reduction of flies and of the incidence of fly-borne diseases such as dysentery and diarrhoea. We do not anticipate the disappearance of draught animals from the roads in India for many years to come, but there is the possibility of a steady increase in motor transport in the larger urban centres and later in the country as a whole and such developments will lead to a reduction of the fly population.

12. Apart from the measures directed against the breeding of flies we recommend that active steps should be taken for the destruction of adult flies by the use of potent insecticides such as D. D. T. and pyrethrum.

## **CONTROL OF CERTAIN TRADES, INDUSTRIES AND OCCUPATIONS DANGEROUS AND OFFENSIVE TO THE COMMUNITY**

### **The Present Position**

1. Some of the provincial Local Self-Government Acts (*e.g.*, the Madras District Municipalities and Local Boards Acts and the Bengal Municipal Act) give power to local authorities to control certain trades, industries and occupations which may prove offensive or dangerous to the community and which are specifically mentioned in those Acts. Provision for such control has been made by the prohibition imposed on the carrying on, by any person, of such trades and occupations within the area of a local authority before obtaining a licence from that authority. By the incorporation of

suitable conditions, the local body concerned can regulate the functioning of these dangerous and offensive trades in the interests of the health and general welfare of the community. For instance, the Bengal Municipal Act provides for the control of a number of such trades which include:—

- (1) Slaughter of animals, their skinning and disembowelling for purpose other than human consumption;
- (2) storing hides, fish, horns or skins;
- (3) boiling or storing offal, blood, bones or rags;
- (4) melting tallow;
- (5) tanning or the manufacture of leather or leather goods;
- (6) oil-boiling;
- (7) soap-making;
- (8) dyeing;
- (9) burning or baking bricks, tiles, pottery or lime;
- (10) storing kerosene, petroleum, naphtha, or any inflammable oil or spirit;
- (11) trading in or storing for other than domestic use, hay, straw, wood, thatching grass, jute or other inflammable material and
- (12) any manufacture, process or business from which offensive or unwholesome smells or offensive noises may arise.

2. In practice the control exercised over such trades by local authorities leaves much to be desired. The fact that a proportion of the revenue of municipalities is derived from the grant of such licences, and pressure from vested interests have, it is believed, been responsible for the laxity that exists in the enforcement of the law.

### RECOMMENDATIONS

3. While the measures required for the control of each of these trades and industries will naturally vary to some extent they should, in general, aim at the regulation (1) of the location of these trades and industries, (2) of the specific processes in individual cases if there be any risk involved in them to the health of the worker, (3) of the general sanitation of the factory so as to provide as hygienic an environment as may be practicable and (4) of the quality of the trade wastes issuing from the factory premises, in order to ensure that their disposal on land or in any large body of water does not produce effects detrimental to the health and welfare of the community.

(1) *Control of Location.*—Some of these industries which cause the emission of offensive smells such as tanning and the boiling of blood, offal and bones should be permitted to operate only at a sufficient distance from inhabited areas to prevent their causing nuisance or their becoming a danger to health. Their location should therefore be restricted to special areas. Other trades, such as the storage of inflammable articles, should not be permitted in the densely populated areas.

(2) *Control of processes involving risk to the health of the worker.*—Such risk arises mainly, from the possibility of contracting industrial diseases, an example being anthrax in tanneries. We recommend that special rules should be made to protect the workmen in such

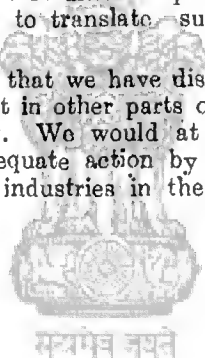
trades. The subject of industrial disease has already been considered by us in the chapter dealing with industrial health.

(3) *Control of the general sanitation of the factory.*—This subject has also been dealt with in some detail in the chapter on industrial health and we need not, therefore, go over the same ground again.

(4) *The treatment of trade wastes and their disposal.*—In dealing with river and beach pollution and with the general sanitation of rural and urban areas we have already recommended that, as the treatment and disposal of trade wastes present many technical problems, the Water and Drainage Boards, suggested by us, should offer advice to Governments on these matters, and that the latter should issue such general and specific instructions as may be required to deal with these problems.

4. Local authorities already possess sufficient powers to deal with these trades and industries. The application of these powers to control such trades will be facilitated by the implementation of our proposals for health development, which include provision for improving local health administration and for placing, at the disposal of the authorities responsible for such administration, suitable technical advice in respect of different problems as they arise and a technical staff competent to translate such advice into effective action.

5. In view of the fact that we have discussed many of the technical aspects of this subject in other parts of the report we have dealt with it here only briefly. We would at the same time stress the urgent importance of adequate action by local health authorities to control such trades and industries in the interests of the public health.



## CHAPTER XV

### QUARANTINE

1. We have discussed at some length the problems of international and internal quarantine from the point of view of India in our review of the subject in Volume I of this report.

#### **International Quarantine**

2. As regards international quarantine there are two aspects requiring consideration. One is prevention of the export of infection in respect of the diseases recognised under the International Sanitary Conventions and the other is that of protecting India from the possible introduction of diseases such as yellow fever, sleeping sickness and others from which the country is at present free. In regard to both, the measures now in force in India are considered reasonably complete and satisfactory.

3. We understand that the International Sanitary Conventions governing sea and air traffic are undergoing some alterations designed mainly to make provision for the changed conditions of international traffic, particularly in respect of air travel, which have come into being in recent years and will no doubt be in evidence to an even greater extent in the future. It is understood, however, that the main principles on which participation between the Governments of different countries for the control of the spread of infectious diseases has hitherto been based will continue unaltered in the new Conventions under consideration. India, while she has so far been carrying out faithfully the requirements of the existing Conventions, has not formally ratified them. We understand that the Government of India has, under active consideration, the question of ratifying the new Conventions and we strongly support their ratification.

4. We are recommending, in Chapter XVII of this volume, that the ratification of international treaties should be one among a small group of subjects in respect of which the Centre should be given the power to compel a province to fall in line with the other provinces. In dealing with problems of international health it is essential that the Central Government should be able to carry out a common policy throughout India. For instance the fact that international air lines pass through different provinces in the country necessitates action on common lines in respect of the health requirements of air ports and their surrounding areas in each case, though the latter will, obviously, be under different Provincial Governments (*e.g.*, antimosquito measures)

#### **Internal Quarantine**

5. Internal quarantine is concerned with the enforcement of measures designed to control the spread of infectious disease between neighbouring units of administration, namely, the Provinces and Indian States. No attempt has so far been made to deal with this problem on a sufficiently comprehensive scale and no organisation exists for the co-ordination of such preventative measures as individual Provinces and States may carry out in their own territories.

6. We need not go into details here regarding the legal provision under the Government of India Act, 1935, for the prevention of the

spread of infectious diseases from one unit of the federation to another. The matter has been dealt with in some detail in our review of the subject in the previous volume. We would, however, emphasise that the need for controlling the spread of epidemic diseases from one part of the country to another is so great that considerations based on the desire to maintain intact the principle of provincial autonomy should not prevent the carrying out of any changes, which may be required in the existing law.

7. It may not be out of place, in this connection, to examine the way in which internal quarantine measures are carried out in the United States of America. In that country each State is sovereign within its own territories so far as internal health functions are concerned. But control of the interstate spread of disease is the responsibility of the Federal Government and of the Federal Health Service. To quote from Smillie's "Public Health Administration in the United States" (1943), "the Federal Health Service has control of sanitation in interstate traffic. Supervision of the sanitary facilities of interstate vehicles is a responsibility of the Federal Government. Ships on the Great Lakes and the waterways, as well as railroad trains, are included, and special attention is given to their water-supply and sewage disposal systems". The Federal Government assists the States in the control of communicable diseases and at the request of a State, the Federal Public Health Service sends trained personnel from its establishment to aid in the suppression of any serious outbreak of epidemic disease within the territory of that State. Among the special measures undertaken by the Division of Domestic Quarantine of the Federal Public Health Service may be mentioned rat control to prevent plague, sanitation of the vessels engaged in interstate traffic and stream pollution where interstate interests are involved. We have described in some detail these internal quarantine duties of the Federal Administration in the United States because we feel that, in developing measures for the control of the spread of infectious diseases from one unit of administration to another in India, the practice in force in the United States can with advantage be adopted here, with such modifications as may be necessary to suit Indian conditions.

8. In the light of the discussion in the preceding paragraphs we make the following recommendations:—

(1) As in the case of the United States, the Central Government should be responsible for the enforcement of all measures necessary to prevent the interprovincial spread of infectious disease. We have already indicated briefly the steps which are taken in that country by the federal authorities for controlling the interstate spread of such diseases. If the existing law in India requires modification in order to enable the Centre to carry out these duties, such modification should be brought about as soon as may be practicable.

(2) As has been explained elsewhere, we desire to see that occasions for intervention by the Centre in the internal administration of a Province should be minimised as far as possible. To secure this end we have suggested the establishment of an organisation, the Central Board of Health, consisting of the Central and Provincial Ministers of Health and have recommended that normally all provincial matters, which may require intervention by the Centre, should first be discussed by the Board in order to secure the largest possible



measure of agreement in respect of the action required to be taken. Where urgency demands immediate action, we have suggested that the Central Minister should report the matter to the Board with the least practicable delay. We believe that, if the proposed procedure can be followed, the possibility of friction between the Centre and the Provinces will be considerably reduced.

In the sphere of internal quarantine we would recommend that the Board should draw up, in consultation with the health advisers at the Centre and in the Provinces, a memorandum of instructions to be followed by the Central and Provincial Health Departments in order to promote the effective control of the spread of infectious diseases. Occasions requiring co-operative action by the Central and Provincial Health Departments will include, among others, (a) large festivals in individual provinces, which attract pilgrims from other provinces, (b) outbreaks of epidemic disease in a province in an extensive form or, even if it be on a smaller scale, in an area close to the borders of a neighbouring province, so as to constitute a threat to the latter and (c) serious calamities such as floods, earthquakes and famines whereby conditions may be created, which are favourable to the rise and spread of epidemics. Some degree of co-operation among the provinces themselves and with the Centre already exists in respect of exchange of epidemiological information and in respect of measures in connection with large festivals. But we desire to see the whole field of possible co-operation examined on a wide basis and a common programme of action drawn up under the auspices of the Central Board of Health. Into such a programme can be fitted the measures which are to be taken by the Centre, including the assistance to be given by it to the Provinces, for the discharge of its own inter-provincial quarantine functions.

(3) The desirability of creating an inter-provincial fund for carrying out the measures outlined above should be considered. To this fund Provincial Governments can contribute their share on some agreed basis. The Central Government should also make a suitable contribution, which would cover its responsibilities for the Centrally Administered Areas as well as for financial assistance towards furthering interprovincial control of the spread of infectious disease. Such a fund will also constitute an insurance for all Governments against possible disasters such as famines, floods and earthquakes.

(4) The measures described in this chapter for the enforcement of internal quarantine can hardly be effective without the active participation of Indian States. In view of the uncertainty regarding possible future developments in the constitutional sphere in India, all that we can recommend is that, by mutual arrangements or in some other way Indian States should also be brought into the scheme. We realise that it is only those States which possess a reasonably good health organisation that can participate in such co-operative effort. The more important of the States will probably satisfy this condition and if, in the beginning, even these can be persuaded to come in, the range of activity of the internal quarantine organisation and its effectiveness will have been greatly increased.

## CHAPTER XVI

### VITAL STATISTICS

#### Introduction

1. Vital statistics constitute the foundation on which all constructive work in the field of public health must be built. Preventive and curative work can be organised on a sound basis only on accurate knowledge regarding the diseases and disabilities prevalent in any area. Such information will become available only when mortality and morbidity statistics are recorded correctly. The reports of the Royal Commission on Agriculture and of the Royal Commission on Labour both drew pointed attention to the defects of Indian vital statistics and stressed the importance of ensuring that an early improvement was effected.

2. In this chapter we shall discuss the measures that are necessary for improving the registration, compilation and study of vital statistics in this country. In its widest sense the term vital statistics includes, as has been pointed out by Sir Arthur Newsholme, "the whole study of man, as affected either by heredity or by environment, so far as the results of this study can be arithmetically stated". It is, at the same time, used in a narrower sense to denote data regarding the occurrence of certain types of vital events taking place in the community, such as births, deaths, the incidence of disease and marriages. As regards marriage no registration normally takes place among the Hindus and Mohammedans, who together constitute about 91 per cent. of the total population. Therefore, in our discussion of the methods of improving vital statistics, we shall confine ourselves to births, deaths and the incidence of disease. The organisation of morbidity statistics for the community presents a difficult problem even in countries in which the development of health services has advanced much more than in India and figures for deaths, in view of their greater completeness, are generally utilised to a greater extent than morbidity figures for the study of health problems, even though the latter constitute more satisfactory material for such study. It is only when an adequate medical service covering the whole population and offering protection to all, irrespective of their ability to pay for such protection, becomes established and operates over a reasonable period of time that morbidity statistics of the requisite quality and quantity will develop. Such a comprehensive service has not yet been established even in the more advanced countries of Europe and America and its provision is only under consideration. In India our proposals aim at providing the country with such a health service and its establishment will no doubt promote here also the growth of a body of reliable statistics covering the field of morbidity in its various forms. For the present, however, there exist morbidity figures, although they are incomplete, for certain infectious diseases which have been made notifiable by the different health authorities in the country. Our proposals in this chapter will cover, besides the statistics relating to births and deaths from all causes, those which relate to the incidence of notifiable diseases also.

3. The application of modern statistical methods to health administration is of supreme importance. The study and interpretation

of vital statistics require the use of these methods. An essential part of sound administration is that it should produce, in all branches of its activity, data which will indicate the trend of events. The application of the science of statistics is necessary both for ensuring that the collection of such data is on sound lines and for assessing the results of administration through a study of the recorded statistics. The study of the social and biological aspects of applied medicine, for instance the investigation of socio-economic factors in relation to community health and disease or the assessment of the value of a particular drug in the treatment of a specific disease, requires the application of statistical methods for the planning of such investigations and the evaluation of their results. In these circumstances our proposals will also deal with the question of the provision of an adequate statistical service in connection with the health organisation. As will be shown later, we consider that such a statistical service should form an integral part of the administrative organisation we are recommending for vital statistics.

4. The size and composition of the population, including its age and sex structure, have an important bearing on health as well as general administration. Population studies should therefore constitute an important function of the administrative organisation we recommend. In addition the census, as a periodical stocktaking of the community in respect of certain types of information closely related to population and vital statistics, should also be made a function of that organisation.

5. For the sake of convenience we summarise below the different matters which will be discussed in this chapter:—

(1) Certain proposals for the improvement of vital statistics in the areas under our scheme of health services.

(2) Certain proposals for the areas which will remain outside our scheme during the earlier stages of the programme.

(3) Certain other proposals for improving vital statistics.

(4) The administrative organisations for vital statistics in local areas, at the headquarters of the Province and at the Centre.

6. Before proceeding to deal with these subjects we may describe briefly the existing system of collection and compilation of vital statistics, although we have dealt with these matters in the previous volume which gives a review of health administration in all its branches.

### **The Present Position**

7. (a) *Registration and compilation.*—Generally speaking, in all municipalities the vital statistics organisation is a part of the municipal public health department. Similarly, Union Boards or *Panchayats*, which are smaller units of local self-government have also been entrusted, in certain provinces, with the task of recording and compiling vital statistics for their own areas. In rural areas the agency for registration is not the same in all provinces. In Madras Presidency the registrar is the village headman. In most other provinces he is the police officer in charge of the *thana* (police station). The average area of a *thana* varies, in the different provinces, from about 127 square miles to 420 square miles and its average population from about 78,000 to 181,000. The man responsible for reporting these statistics from individual villages is the

*chowkidar* (village watchman), who is perhaps the lowest grade of public servant and is generally illiterate. He reports these events to the police station in whose jurisdiction his village is situated at intervals which vary from one to two weeks in different provinces. The recorded vital statistics are passed on through a series of officers to the Director of Public Health. Compilation of the data is carried out at the different stages of transmission. Madras forms an exception to this general statement and the results there have been satisfactory. Here the number of intermediary stages has been reduced. The village headman sends his report to the *Tahsildar* of the *taluk* in which the village is situated and the latter sends it directly to the Director of Public Health. Compilation of the data for the whole province has been centralised in the office of the latter officer.

(b) *Errors*.—The errors fall under three heads, (i) incompleteness in the recording of events, (ii) inaccuracy of the registered cause of death, and (iii) faulty compilation.

8. Of these three types of errors, omissions in registration can be rectified more easily than inaccuracy in respect of the cause of death. As will be shown later, the latter can be remedied only by the provision of an adequate health service for the community. The question of compilation is bound up with the type of organisation that will be provided at different levels of administration and this subject will be discussed after we have dealt with the administrative machinery.

## OUR RECOMMENDATIONS

### Proposals for the Areas under Our Scheme

9. While the replacement of the village *chowkidar* by a more competent agent may not be easy of accomplishment in the near future, we believe that the proposals we have made for the expansion of health services over the country as a whole will materially assist in the rectification of the defects pointed out above.

(a) *The village committee*.—For each village we have suggested the establishment of a village committee, one member of which will concern himself with vital statistics. His local knowledge should enable him to bring on record events which might have escaped the notice of the *chowkidar* while, if he is interested in his duties he can also help in securing better registration by persistent efforts to awaken, in the villagers, a sense of personal responsibility in regard to this matter.

(b) *The primary unit organisation*.—We have recommended the provision of two public health inspectors, four midwives and four public health nurses for each primary unit and it should be a part of their function to collect, in the course of their routine duties, information regarding the occurrence of births, deaths and cases of infectious disease and to pass it on to the registrar. House to house surveys in individual villages and the checking of the figures registered for such villages against their own findings are even now being done by the subordinate public health staff in certain provinces in order to improve vital statistics. The public health nurse and the midwife will come continually in contact with women in the homes they visit and the collection of such information should, therefore, present no difficulty for them. Further, it will be one of their functions to contact as many expectant mothers as possible and to follow

them through childbirth into the postnatal period. We anticipate that the contribution that all these officials will thus make to the improvement of vital statistics on the side of reducing omissions will, in a short time, be considerable.

(c) *The creation of four registration offices in each primary unit.*---The placing of the registering authority as close to the people as possible is desirable in order to improve vital statistics. The size of the *thana* as the unit of registration area is much too large and the weekly or fortnightly visit of the *chowkidar* to the registrar is too infrequent to prove satisfactory from the point of view of health administration. With our health organisation to assist, it should easily be possible to establish four registration offices in each primary unit. One of these should be in the health centre at the headquarters of the primary unit. For the purpose of administration the unit will be divided into four circles and a public health nurse, a midwife and a trained *dai* will be located at the headquarters of each circle for work within its area. It is for consideration whether the public health nurse and midwife should not be made Registrars of Births and Deaths in these circles. The registration office should function at stated hours on two days of the week to enable individual *chowkidars* to attend this office at regular intervals. By locating the nurse and midwife at the same place it should be possible to ensure that one of them is there to keep the office open on the required dates and during the stated hours. We believe that the provision of four registration offices in each primary unit should make it possible for the *chowkidar* to present the information collected by him at the registration centre at least twice a week. In Bengal, for instance, the average area for a *thana* is 127 square miles while that of a primary unit is about 51 square miles. With four registration offices in the latter area it should not be difficult for a *chowkidar* to pay two visits a week or even more. From the point of reporting outbreaks of infectious diseases the gain in time secured is of the utmost importance.

We have suggested the employment of the above mentioned members of the Health Department as registrars with the idea of ensuring a speedy improvement in the registration of vital statistics in the areas covered by our scheme, because we feel that such improvement is fundamental to the success of the health programme. Later in this chapter we have recommended, for the areas outside our scheme, where the health organisation will be much smaller in strength, the appointment of registrars with an elementary type of training. Each should have a reasonable number of villages in his charge so that he should be able to visit every village once a fortnight. Our recommendation for the area in which the health programme is being developed is of a temporary nature. The ultimate aim should be to establish a registration office, with its own registrar, for each large village or group of small villages and thus to make it convenient for the people to report directly at this office cases of births, deaths and notifiable diseases. This matter will be further discussed in the section dealing with the administrative organisation for vital statistics.

(d) *Improvement in the accuracy of the recorded causes of death.*---For improving the accuracy of the registered cause of death

medical certification is necessary. In our view, certification of the cause of death should be a bye-product, if we may so put it, of the normal functioning of an adequate medical service for the community, because a reasonably correct diagnosis of the immediate cause of death can be given only by a physician who has attended the patient during his last illness, while the recording of the remoter causes of his death will require, in addition, information regarding his medical history. No short-cut can, therefore, be devised for promoting the rapid growth of a reliable body of information regarding the true causes of mortality in the community. The completion of the long-term programme, with its relatively large provision for treatment facilities, should secure the achievement of this purpose. In the meantime it is believed that the health organisation proposed under the short-term programme will help, to some extent, in improving the correctness of registration of the cause of death. The two medical officers attached to each primary unit will be able to certify, as the result of personal visits during the last illness of patients, a certain number of deaths, but these are not likely to form an appreciable proportion of the total. At the same time, by utilising the services of the two public health inspectors and the four nurses attached to the primary unit, it should be possible to obtain a reasonable amount of detailed information regarding individual deaths and thus to attempt to reach a more satisfactory diagnosis of the cause in each case than is possible at present on the report of the *chowkidar*. We suggest that this procedure should be adopted in respect of as many deaths as possible so that at least some improvement in this important aspect of vital statistics registration may be effected.

### Proposals for the Areas outside Our Scheme

10. The vital statistics of the areas which will remain outside our scheme during the early stages of development of the health organisation also require attention. Any improvement that can be made in these areas, although it be of no high standard, will help to raise the value of the recorded vital statistics for the country as a whole.

11. The question of employing non-medical personnel, with some elementary type of training, as registrars in the areas to which our health programme has not been extended merits consideration. Such training need not be elaborate. The man must be literate in his own vernacular and should be able to maintain the records entrusted to him. His training should include instruction regarding the signs and symptoms of such common infectious diseases as cholera, smallpox, plague and a few others. His range of jurisdiction should be such as he could cover in a period of about six days. He should stay in the village in which his registration office is situated three days in the week and the different *chowkidars* in his area should be allotted specific days for reporting events for registration. Three other days in the week should be devoted by him to the inspection of a certain number of villages included in his area. The purpose is that, by personal enquiries, he should exercise a check on the work of the *chowkidar* in collecting vital statistics. Such supervision will undoubtedly help to improve the work of the latter. It is desirable that the number of villages included in the jurisdiction of the Registrar should be such as to enable him to visit all of them at least once a fortnight.

12. It will be seen that we are not envisaging the creation of a highly trained type of health worker. We have not even stressed the need for the middle school examination or any such standard of general education. What is required is that he should be literate in his own vernacular and should have had sufficient training to carry out the duties entrusted to him in a reasonably satisfactory manner. The results he may be expected to achieve will be rather in the direction of preventing omissions than of improving the accuracy of registration of the cause of death. The latter can be secured only through a medical agency. Such a worker should be relatively inexpensive to produce and employ; considerations which are important in view of the vast rural regions to be covered by the service. Many of the smaller towns are similar to the rural areas and a registrar of this type will perhaps suffice for such towns also. Adequate provision for the supervision of such staff is of great importance. We shall discuss this question in the section dealing with the administrative organisation.

13. We have described in very general terms our recommendations for the areas outside our scheme and have not gone into such questions as the strength of staff likely to be required and the probable cost of the organisation. We have ventured to make these suggestions because we feel the urgent need for attempting to secure, without delay, some measure of improvement in these areas, although such improvement may be limited to the reduction of omissions in registration. A certain amount of supervision over the work of the *chowkidar* seems to be essential if any degree of progress is to be registered.

#### **Certain other Proposals**

14. *House lists in villages and sample surveys.*—A house list is prepared for every village during the census and we recommend that it should be preserved and kept up-to-date during the intercensal period. As a permanent record it can be of great value to the different departments of Government. The list should contain information regarding the name, date of birth and sex of the head of the family and of every normal resident of the house. The occupation should also be noted, wherever it can be correctly ascertained. It should be made obligatory on the householder to give the information required for the filling of the house list, should he be asked by the appropriate authority to do so.

In a sub-continent like India the use of the sampling method is eminently suitable for the collection of demographic information of various types. Complete enumeration is the method which has been in use for successive censuses. It is cumbersome and the ensuring of accuracy in a gigantic operation of that type is not easy. On the other hand, sample surveys, devised with due safeguards, should serve the purpose almost equally well and with less expense and trouble. The provision of an accurate house list for each village will prove invaluable for such surveys which will have to include not only the selection, on a random basis, of a certain number of specific villages from the total number inhabited by the population sampled but also the selection, on the same basis, of a number of houses in each village. It is for the latter that the house list is of special value.

We may illustrate by examples the types of information that can be secured by the proposed sample surveys. The recorded birth and death rates for specific areas and for the country as a whole are known to be inaccurate but no information is available as to the range of error that exists. Similarly, very little information exists regarding the fertility rates of women in different sections of the population in India. From the experience of other countries it seems quite likely that variation exists in this country also. Birth, death and fertility rates form the basis of all population studies and the need for their ascertainment does not, therefore, require emphasis. Sample surveys can provide information of a reasonable degree of accuracy as well as of great value in respect of all the three.

We consider the preparation of a house list for each village included in our scheme and its maintenance to be of great importance. Without it a periodical assessment of the progress achieved in the different branches of health activity will be difficult. The sampling method can with advantage be used in the different types of health surveys that are undertaken and a house list will be essential for such surveys.

It is most unlikely that the house lists prepared for the 1941 census have been preserved. A special organisation will therefore be necessary to prepare these lists in the areas under our scheme. We recommend, for this purpose, the employment of an adequate temporary staff for the five primary units with which the scheme will start in each district. As a rough guide we suggest that one clerk may be employed to prepare the house list for a primary unit and to mark the houses in that area within a period of one year. One supervisor will be required to check the work of all the clerks in the five units. The total cost within the first 10 years for the eleven Governors' Provinces will be about Rs. 60 lakhs but we consider that the expenditure will be fully justified.

The list for each village may be kept for safe custody in the hands of the *Patwari* or the village headman as the case may be. In provinces such as Bengal, where, owing to Permanent Revenue Settlement, no village Revenue Department organisation exists, special arrangements will have to be made by the Governments concerned.

The task of maintaining the list up-to-date can, it is believed, be undertaken by the primary unit health staff during their visits to individual villages. After a time their efforts in this direction can be supplemented by those of the permanent vital statistics organisation which we are recommending later in this chapter.

We suggest that two or three pages of this house list should be set apart for each house and that the information collected by sample surveys from time to time should be entered in it. The programme of reconstruction, that the Governments in India will start in the post-war period, will bring into the life of the rural community the joint efforts of the various nation-building departments which are concerned with the promotion of social welfare. We have no doubt that such departments will also have information of value to record in the house list from time to time. Thus the latter should, in due course, develop into a valuable document in which will be recorded data covering a variety of aspects of community life in the village.



15. *The provision of adequate incentive for the people to register births and deaths.*—Efforts to improve the administrative machinery and thus produce an increase in vigilance on the part of the governmental staff to secure better registration cannot eventually produce the same results as an awakening of the sense of responsibility of the people to themselves and to the State for recording the vital events that take place in their homes. While the efforts of the health staff through educative work will, no doubt, contribute to this awakening, an effective method of stimulating interest will be by creating conditions requiring, in an increasing degree, the production of proof of age, community, parentage etc. If courts, schools and other institutions could be induced to insist on the production of birth and death certificates, the public will begin to feel the necessity for registering births and deaths in their own interest.

16. *Notifiable diseases.*—There are considerable variations in the number of communicable diseases which are notifiable in the different provinces. For instance, in the Central Provinces their number is about 22, in the Punjab 20 and in the North-West Frontier Province about 7. There do not exist, even in the larger cities, adequate facilities for ensuring that some of these diseases, for example tuberculosis, will be notified in sufficient numbers to ensure that a substantial proportion of the actual occurrences will be brought on record. Existing provision for diagnosis by a medical man and for laboratory aid towards such diagnosis is so meagre in most parts of the country that legal provision requiring the notification of such diseases as cerebro-spinal fever, typhus, typhoid and relapsing fever appears to us to serve little or no useful purpose. These diseases are notifiable in both rural and urban areas in a certain number of provinces. The making of diseases such as sprue and scarlet fever (the latter is quite rare in this country) generally notifiable over a province has, in our view, no justification at all.

We would advise the provincial health authorities to consider seriously the question of revising these lists. Taking into consideration existing facilities, there should be three lists, one for the rural areas and towns under 30,000 population, a second for municipalities from 30,000 to 50,000 inhabitants and the third for all towns and cities above this population. For the first the list should be quite short. Our idea is that there is justification for including in it only such diseases as cholera, smallpox, plague, measles, malaria and a few others with which the people are familiar. The other two lists should include diseases requiring greater medical skill and laboratory facilities for diagnosis, the list for towns above 50,000 containing a larger number than the list for towns with a smaller population.

17. *Compulsory registration of vital statistics.*—In a Memorandum on Indian Vital Statistics, which was discussed by the Central Advisory Board of Health in 1939, it is stated, "There is little doubt that the more general introduction of compulsory registration would have considerable effect in this direction (improvement of vital statistics). Moreover, even in those areas in which registration is compulsory, little or no notice is taken of breaches of the law and a few judiciously selected prosecutions would have a salutary educational effect." As far as we are aware, the position remains practically unchanged. We consider that, in the areas in which our scheme will be introduced, the registration of vital statistics

should be made compulsory along with the introduction of the scheme, wherever such provision does not already exist. In other areas too compulsion should be introduced gradually. We further consider that the enforcement of the law through the prosecution of offenders is essential if definite improvement is to be secured.

### ADMINISTRATIVE ORGANISATION

18. Before formulating our proposals in this connection, there are certain preliminary matters requiring consideration.

(1) Records of births and deaths have a wide range of usefulness and most departments of Government, at one time or other, make use of them. For instance, developmental programmes in such fields as education, agriculture, industry and food must take into consideration the population and its age and sex composition both at present and for many years to come. Estimates providing the required information can be based only on reasonably correct vital statistics. While therefore governmental activity in its varied forms is interested in vital statistics, it is perhaps the Health Department that is most intimately connected with it. It is with the child or the grown-up individual that the other departments are concerned, while births and deaths as events are of supreme importance to the health organisation. The modern conception of a health service includes the provision of adequate protection to every individual from the prenatal stage through childbirth, childhood, adult life and old age to death. Under an ideal health organisation every childbirth will receive such skilled assistance as may be required from the appropriate type of health worker and no death will take place, except as an accident, without a reasonable measure of medical aid being administered to the individual.

In these circumstances, it seems to us that the close association of the Health Department with the vital statistics organisation is of fundamental importance. Completeness of registration and an accurate recording of the cause of death will be secured only through the co-operation of that department. Even so, we consider it undesirable and unwise to combine the vital statistics organisation and the Health Department either during the short-term programme of health development or in the more distant future. During the former period the village *chowkidar* will have to continue as the reporting agent. He is a servant of the Revenue Department and is responsible for discharging a variety of functions besides reporting vital statistics. This in itself makes it impracticable to transfer the administration of vital statistics to the Health Department. Our recommendation for the creation of four registration offices in each primary unit and for making certain health officials Registrars of Births and Deaths has been made solely for the purpose of ensuring an improvement in the vital statistics of the areas concerned simultaneously with development of the proposed health organisation and, as will be shown later, this arrangement will be of a purely temporary nature.

We realise that the functions of the new Vital Statistics Department we are proposing include such matters as the census and various types of demographic studies. These, however useful they may prove to be to the Health Department by throwing light on various

aspects of its own problems, fall clearly outside its legitimate functions. Therefore, the Vital Statistics Department should in our view function as a separate department with its own provincial administrative officer and subordinate officers in the districts. This is the type of organisation we shall recommend presently. We must, at the same time, stress the need for the closest possible co-operation between the two.

(2) We emphasised the importance of providing statistical assistance to the Health Department in its day-to-day administration as well as in the undertaking of various types of health studies. A point for consideration is whether this organisation should form an integral part of the Health Department or whether it would be advantageous to associate it, at least at the provincial level, with the Vital Statistics Department. For reasons which will be set out clearly later, we consider that the latter is the more desirable procedure.

(3) There is an astonishing variation in the quality and quantity of the vital statistics recorded in different parts of the country. Abundant evidence exists indicating that these variations are largely due to differing degrees of incompleteness in registration. We therefore feel that measures for securing a reasonable degree of uniformity among the provinces in respect of registration and compilation of vital statistics are essential.

The responsibility for ensuring such uniformity should rest in our view on the Central Government. In dealing with the functions of the Central Ministry of Health we emphasised the importance of its assisting, through grants-in-aid and technical advice, the development of schemes in the Provinces for the promotion of health in all directions. We feel that improvement of vital statistics is one of the spheres in which such help from the Centre to Provinces is urgently needed.

Mr. Yeatts, the Census Commissioner, pointed out to us that the problem of variation in standards was not peculiar to India and that the question presented itself, sometime back, in an acute form in Canada and in the United States of America. In both countries it was solved by the Centre entering the field through financial assistance, prescription of standards and a constant effort to encourage the constituent States to work up to these standards. Our recommendation is, therefore, based on well-established practice which has proved its usefulness elsewhere.

In the light of the considerations referred to above we may proceed to set out our recommendations. In doing so we shall start with the organisation associated with the Central Government and work our way down to the local areas:—

### **The Central Organisation**

19. Mr. Yeatts described briefly to us the two types of organisation that had been evolved at the federal centre in Canada and the United States. In the former the view is held that the statistics of the different departments of Government should be brought together and that they should be looked upon as a co-ordinated whole. In Canada therefore the statistics relating to the different departments pass through an officer called the Dominion Statistician. It is

reported that the system has worked well but, under it, the directional head would require to be a man of considerable experience and ability in order to determine what items of information should be discarded and what insisted upon. In the United States there is a Bureau of the Census which, although its primary function, as its name implies, is to handle data bearing on population, deals also with vital statistics. Individual departments have their own statistical organisations. Some years ago it was found essential to appoint a Central Statistics Board to bring the various departmental organisations together and to impose common principles of standards and co-ordination. This Board has, we believe, been merged in the Bureau of the Budget but the principle of observing common standards and of co-ordination is still, we understand, being applied.

For India we consider the Canadian model of a single statistical officer, under whose review must pass the statistics of all departments, is hardly practicable, as the strain on the individual would become unbearable. The population of this country is about sixty times that of Canada and the volume of statistical material to be dealt with here will consequently be so much greater by comparison as to make the Canadian example inapplicable to India. At the same time, we are of the opinion that the census, population studies and vital statistics should be handled together in view of their intimate relationship. This, we believe, is the position in the United States. We prefer, however, to substitute for the United States organisation, namely the Bureau of the Census, an officer with the title of Registrar General of Vital and Population Statistics.

There is the need, as in the case of the United States, for a Committee to co-ordinate the functions of the different statistical organisations that will be maintained by the Central Government. We understand that such a Committee already exists or that its constitution is actively under consideration. We recommend its establishment as soon as possible.

The Registrar General will be responsible, under the administrative control of the Central Ministry of Health, for carrying out the following functions in regard to vital statistics and health studies which we have included in Chapter XVII of this volume of the report, among the functions of that Ministry:

"To collect, tabulate and publish the vital statistics of the various component parts; to undertake a periodical census at such intervals as may be laid down by law; to direct the organisation and the carrying out of statistical studies in any part of the country designed to throw light on any aspect of the health problem."

In addition to these functions he should prepare an annual report on the population of India incorporating such information as is available regarding existing conditions and possible tendencies for the future. It is essential that the Registrar General should be able to express his views freely. The published report should therefore reproduce the independent professional views of that officer, with such comments as the Central Government may deem necessary to make on these views. The Registrar General should have the right of direct access to the Minister to whom he is attached and of free communication with other departments of Government.

It follows from an enumeration of his functions that he should be attached to the Ministry of Health and not to any other department of the Central Government. He will work independently of the Central Health Department but in close co-operation with it.

20. *Qualifications of the Registrar General.*—A scientific background including, if possible, special training in statistics is most desirable. In addition, he should be a man of personality with powers of direction and administration and capable of initiating and developing methods to improve vital statistics taking into consideration the special circumstances of the country.

21. *Provision for statistical advice to the Central Health Department.*—We suggest that provision for statistical help to the Central Health Department in its day to day administration or in the carrying out of special investigations may be made by creating a 'medical section' in the Registrar General's office. This section, which will consist of statisticians and whose budget will be part of that of the Central Health Department, will be located in the Registrar General's office for the purpose of securing the technical supervision of that officer. The functions of the latter, consisting as they do of vital statistics, population studies and the census, are all of interest to the Health Department. Further, in the investigation of the Department's own problems, the reservoir of statistical material available in the Registrar General's office may often prove to be of great value and sometimes even essential. In these circumstances we believe that the location of the medical statistical unit in the Registrar General's office will be of definite advantage to the Health Department.

#### **The Organisation at the Provincial Headquarters**

22. The provincial statistical organisation should correspond to that which we have proposed for the centre and the functions of the provincial officer in charge should be similar to those of the Registrar General. The designation of the provincial officer may be, it is suggested, the Provincial Registrar of Vital and Population Statistics. He should be attached to the Provincial Ministry of Health for administrative control and should work independently of, but in close co-operation with, the Director of Health Services. He should be responsible for the administration of the provincial Vital Statistics Department and should, like the Registrar General with the Central Government, publish an annual report on similar lines.

The provision of a 'medical section' in the office of the Provincial Registrar for the same functions as those enumerated in connection with the Central Health Department is also necessary.

#### **The District Organisation**

23. This we may consider under two heads, namely, (1) the organisation desirable as a long-term measure and (2) that which is necessary for the immediate future.

(1) *Long-term.*—For determining what should be the ultimate form of the vital statistics organisation in the districts it is desirable to keep the following considerations in view:—

(a) Events taking place in a family should be reported by a member of that family and not at second or third hand, as is now

being done by the *chowkidar*. First hand reporting can alone ensure a reasonable measure of accuracy.

(b) This postulates that the registration office should be placed as close to the people as possible. As has already been pointed out earlier, every large village or every group of small villages must have its own registration office.

With four registration offices in each primary unit the possibility of introducing first hand reporting should be investigated in the areas under our scheme even during the short-term programme.

(c) The registrar must be trained for his work and he should, besides attending his office at stated hours, inspect the area under his jurisdiction in order to ensure that unregistered events, if any, are brought on record. He will therefore have to be a full-time public servant.

We have emphasised, earlier in this chapter, the importance of making compulsory, by stages, the registration of vital statistics in those areas in which such a provision does not exist at present. We are confident that the enforcement of the law and the development of an attitude of responsibility among the people for the reporting of the vital events taking place in their homes, through the measures we have recommended, will together promote a gradual approach towards completeness of registration. Nevertheless we believe that, for a long time to come, the outdoor work of the registrar will constitute a valuable aid towards eliminating omissions in registration and that such inspections by him cannot therefore be dispensed with.

(d) There is no need for a large-scale provision for the supervision of these registrars. Under the long-term programme, when our health services will have extended over the country as a whole, the reporting of births, deaths and cases of notifiable diseases to the registrar should prove to be practically complete if, through the issue of executive instructions or through legal provision, such reporting can be made a function of certain members of the health services such as midwives, public health nurses and doctors. Even now, in many municipalities, midwives are required to report to the health authority such births and medical men such cases of infectious disease as come within their cognisance during the course of their professional duties. Similar provision in respect of the members of the Health Department of the future will not therefore constitute a departure from existing practice. In these circumstances the main function of the superior administrative staff of the Vital Statistics Department in a district will be to ensure, by touring and inspection, that the large number of registrars distributed over the whole area carry out their function of registration properly. In addition there will be the normal administrative duties associated with the maintenance of such an organisation.

Taking into consideration the points discussed above we consider that, as a long-term measure, the district organisation will consist of a District Registrar of Vital and Population Statistics with a certain number of Assistant Registrars located in suitable places in the district. Their number is not likely to exceed six or seven.

(2) *The immediate future.*—We must take into account the fact that, during this period, the village *chowkidar* will continue as the

reporting agent and that control over him is vested in the Revenue Department. We must also take into account our proposals for the appointment of registrars with an elementary type of training in the areas outside our scheme. Adequate supervision over the latter will have to become immediately the responsibility of the district vital statistics organisation.

As regards the area under our scheme the registrars will be, in the beginning, members of the health department. But this system need not continue beyond the first ten years. At the end of this period the registration offices in these areas should also pass under the control of the Vital Statistics Department. The latter should, in the meantime, have had some experience of training and supervising the work of registrars in the areas outside our scheme and an extension of the same system into the areas in which the health staff have been carrying on this function should, in our view, present no difficulty. Even after such transfer there should be the closest co-operation between the Vital Statistics and Health Departments.

In the circumstances discussed above we recommend the appointment of a District Registrar and two Assistant Registrars in the immediate future. These officers are likely to find their hands full during the early years with the organisation of the work of the new department in the areas in which our scheme will not be working. For this reason as well as for the fact that dual administrative control is undesirable, we suggest that the work of the health department registrars should be supervised by their own superior officers in that department. It will be remembered, in this connection, that even now registrars of vital statistics in municipal areas are, generally speaking, attached to the municipal health department in the different provinces. This proposal of ours is therefore not without precedent. The weekly, monthly and other returns and reports which these registrars should submit will go, through their immediate superior, the Medical Officer in charge of the Primary unit, to the District Registrar.

The District Registrar and his Assistant Registrars should be qualified statisticians because they will constitute the staff through whom the Provincial Registrar will have to carry out his investigations in vital statistics and population problems as well as organise and conduct the periodical census. We realise that, in the early stages, it may not be possible to obtain statisticians in sufficient numbers.

The District Registrar will require the close co-operation of the Revenue Department. Indeed, we have in Chapter XVII of this volume of the report emphasised the need for the closest co-operation between all departments in a district whose work has a bearing on its health progress and have expressed the hope that the Collector or the Deputy Commissioner, as the case may be, will be able to secure co-ordinated effort on the part of all district officials so that advance on a broad front may be ensured.

The question of statistical assistance to the district health organisation remains to be considered. It is of the utmost importance to provide, from the very beginning, for the recording of all relevant data in respect of all branches of health administration. Most of this information will be collected on uniform schedules prescribed by the Director of Health Services with the assistance of the "medical

section" in the Provincial Registrar's office. In addition, there may be, in individual districts, certain types of information collected in respect of local problems. All this information should be properly compiled and studied from the beginning. The type of work to be performed is likely to be in the nature of compilation and other forms of elementary statistical treatment. For special investigations help should always be forthcoming from the statistical organisation at the disposal of the Director of Health Services. We therefore feel that, at least in the beginning, it will be sufficient if the officer in charge of the District Health Services is given a Statistical Clerk with some training in elementary statistical methods, with an Assistant if the volume of work justifies this. In view of the intimate association that this work has with district health administration, we consider that the statistical clerk proposed should be attached to the District Health Department and not to the District Registrar.

We consider the proposals set out in the preceding paragraphs as the most effective for the purpose of organising the registration, compilation and study of vital statistics in the country but recognise that, in view of existing arrangements, it may be some time before full effect can be given to these recommendations. It is, at the same time, essential that, in the areas under our scheme, our proposals for the improvement of vital statistics should be given effect to simultaneously with the introduction of the new health organisation.

#### **Compilation of Vital Statistics**

24. It has been the experience that the greater the number of stages at which compilation takes place the more will be the chance of mistakes. In Madras compilation was centralised, some years back, in the office of the Director of Public Health and the results have been satisfactory. In 1939 the Central Advisory Board of Health recommended that this procedure should be adopted by other provinces. The mistakes produced by local compilation in the past have been partly due to the fact that the staff employed has had no special training in dealing with figures and that supervision has either been absent or quite inadequate. In view of the highly trained superior staff we are recommending for the Vital Statistics Department we suggest that the first stage of tabulation may be in the office of the District Registrar. From there the figures will pass on to the office of the Provincial Registrar. Efficient and speedy tabulation requires the use of modern calculating machines and a multiplicity of compilation centres will increase expenditure on such machines. At the district headquarters the provision of such equipment for statistical work is of great importance because we anticipate that the District Registrar will be called upon to undertake investigations and carry out statistical studies of a relatively high order.

As has already been pointed out the vital statistics returns from the primary units in the areas under our scheme will also go to the District Registrar for compilation.

#### **Provision of Training Facilities for Statisticians**

25. The proposals set out in this chapter require the employment of a large number of trained statisticians. In addition the demands for such personnel on the part of other departments of Government, which are concerned with post-war reconstruction, will also be great.



In the west, industry is also absorbing statisticians because the employment of modern statistical methods is found to be of value in determining uniformity of standards of production. This tendency will sooner or later develop in India also. We therefore feel that the need for organising facilities for statistical training in this country is urgent. We put forward the following suggestions for consideration by the authorities concerned. We must, however, state at once that we have not given the subject the consideration that it deserves and that our proposals are not based on a review of all the facilities that may exist in different parts of the country. Even so we hope that our suggestions may prove to be of some value.

(1) The Indian Statistical Institute in Calcutta possesses facilities of a high order. Under the leadership of Professor P. C. Mahalanobis, F.R.S., a body of keen and efficient workers in the field of statistics has grown up and some of them have already made valuable contributions to the theory of statistics. The Institute has a valuable library and its experience in the sphere of statistical field studies is extensive. It has been conducting, for a certain number of years, different courses of training and examinations in the subject. This institution therefore seems to be eminently fitted for development as a centre for statistical training.

(2) We understand that, under the auspices of the Imperial Council of Agricultural Research, courses of training for different types of statistical workers, with a special bias towards agriculture, are being organised. It may thus be possible to develop another training centre in Delhi which, we suggest, may be associated with Delhi University.

(3) As regards statistical work in the field of health, we recommend the creation of a Chair of Statistics in the proposed All-India Medical Institute. The Delhi health organisation with its field training facilities will make it possible for practical instruction to be combined with the theoretical training given at the Institute. The All-India Institute of Hygiene and Public Health, Calcutta, and the Singur Health Centre can also provide similar training facilities for North-eastern India.

(4) As in other fields of education, the ultimate responsibility for developing instruction in statistics must be with the universities. We understand that certain universities have recently provided facilities for training in statistics. We consider it desirable that steps should be taken without delay to develop the teaching of statistics in the universities, where such facilities do not exist, and that provision should be made for the highest possible type of instruction. The services of a few statisticians of standing from abroad, if necessary, should be secured on short-term contracts and suitable selected candidates from India should be sent for overseas training, in order to ensure that the development of these facilities at the universities is proceeded with expeditiously.

## CHAPTER XVII

### ORGANISATION AND ADMINISTRATION

1. In Chapter III, we discussed briefly the structure and functions of the health organisations we propose for assisting the Ministries of Health at the Centre and in the Provinces and for carrying out health administration in the districts. We referred also to their inter-relationships. These subjects will now be considered in greater detail. In doing so, we desire to avoid, as far as possible, traversing the ground already covered and shall, therefore, refer to the points raised in Chapter III in the briefest manner possible. The purpose of making such a reference is to secure completeness of presentation of the matters under consideration. The points we stressed in Chapter III are restated below:—

(1) It is of fundamental importance that the development of the future health programme should be entrusted to Ministers of Health, Central and Provincial, who will be responsible to the people and pay full regard to public opinion.

(2) The task of developing the health programme is of such magnitude that it is considered essential to have a separate Minister to deal with this subject alone both at the Centre and in the Provinces.

(3) The Ministry of Health, Central or Provincial, should be the ultimate authority responsible for all health services operating within its jurisdiction. It should lay down minimum standards of health administration for those services which are within the immediate control of other departments (e.g., railways, prisons, education, etc.) and should endeavour to see them enforced.

(4) There should be the closest possible co-operation between the Ministry of Health and other departments of Government in order to promote the pooling of all available facilities, curative and preventive, in the interests of efficiency and economy.

(5) The Ministers of Health, Central and Provincial, should have the advice and guidance of technical experts in the planning and maintenance of the health services. We recommend the creation of standing councils of experts, at the three levels of Central, Provincial and local area administrations. These councils should consist of representatives of the medical, dental, nursing and other professions from which the health services will be drawn.

Our proposals regarding these councils will be set out in greater detail later in this chapter.

(6) The Minister of Health at the Centre or in a Province should have a technical adviser who will function under him as the single administrative officer for the control of the curative and preventive departments of health. We consider this unification of functions in one administrative officer as fundamental to the success of the future health programme. We have stressed, in more than one place in this report, the importance of dovetailing remedial and preventive measures, wherever possible. The same unification of functions in the administrative sphere is essential throughout the lower levels of administration in each district. Our recommendations regarding the health organisations for the short and long-term programmes, which have been described in the two previous chapters, are based on this principle.

We suggest that the technical adviser under the Central Ministry may be designated the Director-General of Health Services and the corresponding officer in the provinces, the Director of Health Services.

The choice of suitable incumbents of these posts at the Centre and in the Provinces is all important. This subject and other relevant matters will be discussed in greater detail in that section of the present chapter which deals with the recruitment, conditions of service and administrative control of the health services.

(7) The relationship between the Centre and the Provinces in respect of health administration requires careful consideration. The distribution of health functions under the Government of India Act, 1935, has transferred medical relief, public health and most of the duties, which vitally affect the health of the community, to the provinces and, in such matters, the Centre has no powers of intervention. The functions of the Government of India are mainly confined to India's international health obligations and to the administration of health in the areas for which the Centre is directly responsible under the Act. The principle of decentralisation was accepted by the Government of India about thirty years ago. In their Resolution, Department of Education (Sanitary Nos. 888—908, dated the 23rd May 1914, the Government of India announced that it was its policy to keep the control of research under itself but to decentralise other branches of public health administration. The principle received legislative sanction in the Government of India Act of 1919, and in 1935 the position was made clearer in the new Government of India Act by the retention of the *status quo* in respect of the health subjects transferred to the Provinces in 1919 and by the conferment on Provincial Governments of a measure of autonomy which was not provided in the earlier Act.

While the main functions (legislative and executive) in regard to health administration are entirely within the purview of the Provinces, there is provision for concurrent legislation by the Central and Provincial Legislatures in respect of certain subjects, such as the medical profession, factories, labour welfare including industrial health insurance and prevention of the extension from one unit of the Federation to another of infectious diseases or pests affecting men, animals or plants. The executive authority in respect of all the subjects in the concurrent field of legislation is vested in Provincial Governments. For some of these subjects, however, (which include factories, labour welfare and inter-provincial spread of infectious diseases) any Central Act that may be enacted can vest power in the Central Government to issue directions to the Provinces regarding the execution of the provisions of that Act. In the event of failure on the part of a Province to carry out such directions, however, the procedure for enforcing performance is not quick and effective enough to ensure prompt and energetic action in such matters as the inter-provincial spread of infectious disease.

2. It is against this background of the existing relationship between the Centre and the Provinces that we must consider our proposals for the development of a comprehensive health programme. We are proceeding on two basic assumptions. The first is that there may be one or more self-governing units in the country and the second is that the component parts of individual units will have the largest measure of autonomy consistent with the interests of the whole of which they form parts.

3. It will be helpful to discuss briefly the conditions which, in our view, are essential for the successful implementation of our scheme. Our proposals demand a wide departure from present day methods of health administration and professional education. If satisfactory results are to be achieved, it is our considered opinion that mutual consultation and active co-operation between the Centre and the Provinces should be promoted to the utmost extent possible. It is eminently desirable that the health programme should develop, as far as practicable, on fairly uniform lines in the different provinces. This postulates an agency which will assist co-ordination and, in our view, the Central Government is the proper authority to fulfil this role. Our report can provide only the main outlines of the picture of future health administration. Many details have to be filled in, certain alterations have to be made to adapt our proposals to local conditions and the new scheme has, in its application, to be integrated as far as possible with existing health services. As regards the training of future doctors and other health workers, our recommendations provide for a departure from existing methods. In the circumstances, action by the Central Government on the lines indicated below seems to be desirable in order to give an impetus to the development of the health programme throughout the country.

- (1) The Central Government should demonstrate in a selected area the application of all our proposals in the various fields of health activity. Some of us are of the opinion that this demonstration should be carried out in the Delhi Province, while others would leave the selection of the area to the Government of India. Such a demonstration centre is considered essential for developing administrative technique suitable to our programme of health services and to indicate how the new ideas can be incorporated in the training programme for medical and other health workers. The results achieved in this demonstration centre should be of great value to the provinces, while the training facilities made available here can also serve an all-India purpose, at least in respect of certain types of personnel.
- (2) The Centre should help the provinces with grants-in-aid for the promotion of specific lines of health activity.
- (3) The Central Government should provide, when a province so requires, the services of specialists in different branches of health administration, in professional education and in research. We shall deal with the subject of the provision of aid to the provinces from the Centre in greater detail later in this chapter.

4. In addition, we consider it essential that machinery should be established for promoting consultation between the Centre and the Provinces in the formulation of health policy and in its execution with the least possible friction.

5. Can these objectives be achieved within the framework of the existing constitution and the specific division of functions between the Centre and the Provinces which that constitution has established? We believe that, in a large measure, these objectives can be achieved by the development of proper administrative procedure and thereby of conventions which will deter any fundamental departure from

approved practice either on the part of the Centre or of a Province. In coming to this conclusion, we are guided mainly by the consideration that the principle of autonomy of provinces in health matters which has been accepted and followed for sometime past, should not be set aside unless it can be shown that a reversal of this policy is essential for the development of the national health programme. It must be remembered that certain provinces have populations and areas larger than those of many European countries, and local health problems are, therefore, likely to be of such magnitude that they can be dealt with satisfactorily only when Provincial Governments possess a large measure of freedom to experiment and learn by the method of trial and error. In a subcontinent of the size of India, it seems almost certain that progress on sound lines cannot be made through an administration based on a highly centralised authority which may not secure the active co-operation of the provinces. In our view, there will be so much opposition to a resumption of control by the Centre that it will become difficult to create and maintain that atmosphere of goodwill, which we consider essential for the success of our scheme.

6. At the same time, we realise that the existing constitution does not provide for speedy and effective intervention by the Centre even in circumstances in which dereliction of duty by a Provincial Government jeopardises the health not only of those under its charge but also of those living in areas outside its jurisdiction. Health activities fall broadly into one or other of the following groups, (1) those in which action should be purely provincial, (2) those which require co-ordination of provincial activities by the Centre, (3) those in which the Centre may exercise powers delegated to it by a province and (4) those in which the Centre should have power to take direct action in a province or provinces in the interests of the country as a whole. Examples of the last group are occasions when the Centre should take action to prevent the inter-provincial spread of communicable diseases or to compel a province to fall in line with the rest of the country in regard to international treaties.

7. We presume, however, that, if our suggestions regarding the provision of grants-in-aid and technical assistance to provinces by the Centre can be carried out and if suitable machinery can be devised for mutual consultation and co-ordination of effort in the development of the health programme, occasions for intervention by the Centre, even in the limited sphere suggested above, should prove to be exceptional. Towards the development of such co-operation we are suggesting the creation of a Statutory Central Board of Health, which will be responsible for discussing and forming health policy and for promoting its implementation with the least possible friction between the Centre and the Provinces. Even so, we cannot help feeling that legal sanction may have to be provided to enable the Centre to intervene in the affairs of a Province in certain exceptional cases to which we have referred above. To us the provisions of the Government of India Act, 1935, are not sacrosanct, and we have no hesitation in saying that, while keeping in view the broad principle that provincial autonomy should, as far as possible, be respected, no limitation set by the present constitution should debar the country from proceeding successfully with the health programme under consideration.

It is not our intention to review the existing provisions of the Government of India Act, 1935, which regulate the relationship

between the Government of India and Provincial Governments or to suggest suitable alterations to these provisions in order to meet the requirements we have indicated. This task we must leave to the authorities concerned with such matters.

While we realise that changes in the existing law may be necessary to give effect to some of our recommendations, we must reaffirm our view that the measures for consultation and co-operation which we are suggesting will perhaps provide the safest foundation on which lasting progress can be attained. We are strengthened in this view by an examination of the relationship between the Federal and State Governments in the United States of America in respect of health administration.

8. This relationship has been described succinctly by Smillie in his book, "Public Health Administration in the United States" (1943). "The State", he says, "*is the sovereign power and not the Federal Government. Each State is autonomous in all the matters relating to public health within its own borders. These powers are delegated to the State by the constitution. The Federal Government possesses only those functions and powers that are specifically designated to it by the several States.*"

The need for the active co-operation of the Federal Government with State Governments in the development of a national health policy was emphasised by the Committee on Economic Security which made its report to President Roosevelt in 1935. The Committee stated:—

"It has long been recognised that the Federal, State and local Governments all have responsibilities for the protection of all the population against disease. The Federal Government has recognised its responsibility in this respect in the public health activities of several of its departments. There also are well established precedents for Federal aid for State health administration and for local public health facilities, and for the loan of technical personnel to States and localities. . What we recommend involves no departure from previous practices but, an extension of policies that have long been followed and are of proven worth. What is contemplated is a Nation-wide public health programme, financially and technically aided by the Federal Government, but supported and administered by the State and local health departments."

The Committee recommended that funds should be made available for:—

- (1) an increase of public health activity by the Federal Government itself and
- (2) provision of grants-in-aid to States for:—
  - (a) the development of State health department activities and
  - (b) the development of local health services in communities that are unable to finance adequate health protection programmes.

These recommendations were embodied by the Congress in the Social Security Act of August 14, 1935. The Act has titles which are shown below:—

#### I. Grants to States for old-age assistance.

- II. Federal old-age benefits.
- III. Grants to States for employment compensation administration.
- IV. Grants to States for aid to dependent children.
- V. Grants to States for maternal and child welfare.
- VI. Public health work.
- VII. Social Security Board.
- VIII. Taxes with respect to employment.
- IX. Tax on employers of eight or more persons.
- X. Grants to States for aid to the blind.
- XI. General Provisions.

Under the Act, public health work was assigned to the U. S. Public Health Service.

The allotment to each State was determined on the basis of (1) population, (2) special health problems and (3) financial need and was contingent upon the establishment by it of a properly organised State health department on a fulltime basis. The help rendered is partly through the grant of subsidies and partly through the assignment of trained personnel from the Federal Public Health Service to work in individual States for limited periods of time.

Decentralisation of health functions appears to be at least as complete in the U. S. A. as it is in British India. Nevertheless, a large measure of co-operation seems to have been established in the field of health administration in that country.

9. We may now proceed to discuss the Health Organisation we propose for India, which will consist of the following:—

- (1) a Ministry of Health at the Centre;
- (2) Ministries of Health in the Provinces and
- (3) local area health administrations.

For reasons, which we have already discussed in our proposals for the long-term programme and to which we have again referred briefly earlier in the present chapter, we recommend the establishment of two advisory bodies, the Health Board and the Health Council, at each of the three levels of administration indicated above. We shall now consider the functions of each type of health authority and of its associated advisory bodies.

### **The Central Ministry of Health**

10. As we have already pointed out earlier in this chapter, the Minister will have at his command the services of a highly qualified technical officer—the Director General of Health Services. The functions of the Central Ministry will, among others, include the following:—

- (i) To study and plan schemes of health services, preventive and curative, for the whole of India; to revise or modify such schemes from time to time and to assist and co-ordinate activities for the extension and improvement of health services in the provinces.

- (ii) To assist in the provision of proper facilities for the education of medical and auxiliary personnel throughout India.
- (iii) To provide for medical research and the training of research personnel for central purposes and to assist and encourage medical research and the training of research personnel in the provinces.
- (iv) To co-ordinate the activities of all workers in the field of public health and of all existing medical institutions and organisations conducted by every type of agency, both official and non-official, statutory and private; to augment such provisions where necessary so as to make them available to all, rich and poor alike.
- (v) To meet the obligations assumed by the Central Government under the provisions of international treaties.
- (vi) To collect, tabulate and publish the vital statistics of the various component parts; to undertake a periodical census at such intervals as may be laid down by law; to direct the organisation and the carrying out of statistical studies in any part of the country designed to throw light on any aspect of the health problem.
- (vii) To carry out all such health measures as are required for (1) the control of interprovincial spread of communicable diseases, (2) the sanitary control of interprovincial traffic and (3) control of food and drugs in interprovincial commerce.
- (viii) To establish and enforce standards of control for the manufacture and sale of drugs and biological products used in the treatment of diseases.
- (ix) To assist the provinces, and through them local health administrations, in their health programmes; the assistance given by the Centre to the Provinces may be either technical or financial or both, as circumstances may require, and may be subject to such terms and conditions as the centre may lay down.
- (x) To take such legislative or executive action as may be provided by the Constitution as being action in respect of which all-India measures are necessary to safeguard the health of the country.

In the exercise of these functions it would have no power to impose its views on the provinces except in the cases referred to in (v), (vi), (vii), (viii) and (x).

### **The Statutory Central Board of Health**

11. We recommend the creation of a Statutory Central Board of Health which will consist of the Minister of Health at the Centre and the Ministers of Health in the Provinces. The Central Minister will be the Chairman of the Board. The Director-General of Health Services and the Provincial Directors should normally be in attendance at the meetings of the Board, but they should have no power to vote when decisions are taken.

12. The Board is intended to provide a forum for the discussion of health policy and for facilitating its execution with the fullest possible measure of co-operation between the Centre and the Provinces.



13. We have already expressed our view that the programme of health development, which we have advocated, cannot be carried out effectively in the provinces unless the Central Government is willing to provide financial aid to Provincial Governments. One of the important functions of the Board should be that of making recommendations to the Central Government regarding the distribution of grants-in-aid. While the Board will no doubt develop its own procedure for making such recommendations and for reviewing periodically the work accomplished in different areas through the utilisation of these grants, we believe that the following suggestions may prove to be of value for regulating procedure:—

- (i) Individual provinces should develop their own resources as much as possible. The Centre should not be considered as the main source of help for all developmental programmes. Responsibility for the health of their inhabitants is primarily on Provincial Governments. While it is true that the taxable capacity and natural resources of these Governments do vary and that the poorer provinces should therefore have a greater claim on Central help, we believe that the Government of India and other Provincial Governments have the right to maintain that these poorer provinces should demonstrate that they have done their best to exploit to the full their financial resources.
- (ii) Where a matter of all-India importance is involved, such as the production of quinine, and where certain provinces are in the privileged position of being the sole producers, the public interest requires that production and distribution should not be on the basis of an unreasonable profit for the Provincial Governments concerned. Special conditions of climate and soil are of importance in the cultivation of cinchona and pyrethrum and possibly of other plants yielding various substances of medicinal value. As such conditions will probably restrict the areas suitable for cultivation to the territories under the jurisdiction of certain Governments, it is only through the development of an agreed policy that increased production and equitable distribution of such drugs can be promoted. The Board constitutes the machinery through which the formulation of a policy based on common agreement can be attempted, while Central grants to stimulate the production and distribution of these drugs can help to neutralise the profitmaking tendency, which may be expected to emerge if development were left as the sole responsibility of the Provincial Governments concerned.
- (iii) The grants should be, as far as practicable, for specific purposes so that it would be possible to estimate from time to time whether those purposes were being fulfilled. The grants should be accompanied by suitable conditions regulating, among other things, the employment by Provincial Governments, on the schemes concerned, of persons with approved technical qualifications, visits by the technical and administrative officers of the Central

Government in connection with such schemes and submission by Provincial Governments of such periodical reports and returns as may be prescribed. Subject to these conditions, it is desirable that the grants should be made as block grants for a specific period of years in order to provide assurance to Provincial Governments in regard to continuity of financial assistance during that period.

14. We have suggested that the Board should review, from time to time, the work accomplished in the Provinces through the utilisation of these grants. Such reviews will naturally form part of the procedure enabling the Board to make recommendations regarding the continuance or termination of specific schemes.

15. We have referred to certain special circumstances which may necessitate active intervention by the Centre in provincial administration in order to protect the health of the country as a whole. It is recognised that, on such occasions, the decisions must lie with the Central Government. Nevertheless we recommend that, except on occasions requiring action which brooks no delay, the Central Government should intervene in the provincial administration only after consulting the Board. Whenever emergent action is taken, the matter should be reported to the Board without delay.

#### **Central Health Council of Experts**

16. The creation of standing councils of experts at the three levels of Central, Provincial and local area administrations has already been suggested. In chapter III we quoted from the White Paper recently issued by the Ministry of Health in England embodying proposals for a national health service, in order to show that this Ministry considered it essential to provide special devices for enabling the Minister and local authorities to secure the advice and guidance of technical experts. The White Paper has therefore made provision for the establishment of Health Services Councils at the Centre and in local areas.

17. The function of the Central Council proposed in the White Paper will be to express the expert view on any technical aspect of the organisation and functioning of the health service. "It will be entitled to advise, not only on matters referred to it by the Minister, but on any matters within its province on which it feels it right to express its expert opinion." In addition to regular and general consultations, it is proposed that the Minister should refer to the Central Council in draft form any general regulations which he proposes to make in the new service on subjects within its expert field. This Council will consist of about 30 to 40 members representing medical organisations (specialist and general) voluntary and municipal hospitals, medical teaching and professions such as dentistry, pharmacy, nursing and midwifery.

18. We recommend that a technical committee of the kind envisaged in England should also be established in India in order to give expert advice to the Central Government on all matters relating to the organisation and control of the future health services. This body, which may be designated the Central Health Council, should be purely advisory and its purpose will be to give advice to the Minister on technical matters.

19. It is suggested that the Central Health Council should, in the first instance, be appointed by the Minister. It should elect its own Chairman and define its methods of procedure and, as has been suggested in the White Paper in England, the Minister should provide it with the necessary funds and staff for the discharge of its functions. It should be a self-perpetuating body, a certain number of its members retiring each year. Replacement should be made from distinguished members of the professions to which the retiring individuals belong, through election by the existing members of the council. It is recognised that this procedure may be objected to on the ground that the inclusion of persons representing the views of the respective professions may be prevented by those who are already on the Council. On the other hand, the normal democratic procedure of voting on a wide franchise may not, in this case, prove to be a satisfactory method of ensuring the selection of individuals of adequate technical competence and of the highest standing in each profession. If the Council nominated by the Minister on the first occasion consists of suitable persons, there is reason to believe that the procedure of self-perpetuation, outlined above, might afford a better chance of the selection of successors to those who go out at intervals, being based on the dual requirements of ability and standing in the profession.

#### **The Provincial Ministry of Health**

20. The Provincial Minister will, as in the case of the Minister at the Centre, have the services of an expert technical officer who, we have suggested, should be called the Director of Health Services. The functions of the Provincial Ministry will include, among others, the following:—

- (i) Study of provincial health problems and the planning of schemes for their solution; provision for the early diagnosis of disease and for adequate curative and preventive treatment for it either through insurance or non-insurance schemes, such schemes being implemented directly from provincial funds or through assistance to local authorities and voluntary organisations; provision of machinery for the co-ordination of, and technical supervision over, health measures throughout the province.
- (ii) Enactment of regulations dealing with sanitation, disease control and public health which have the force of law throughout the province.
- (iii) Establishment and enforcement of minimum standards of performance of work of health departments, particularly in communities receiving state aid for public health.
- (iv) Maintenance of a central laboratory, and where necessary branch laboratories, for the standard functions of diagnostic, sanitary and chemical examinations; production or procurement of therapeutic and prophylactic preparations, and their free distribution for public health purposes; establishment of standards for the conduct of diagnostic laboratories throughout the province and laboratory research into the causes and means of control of preventable diseases.

- (v) Collection, tabulation, and publication of vital statistics for each important political or health administrative unit of the province and for the province as a whole.
- (vi) Collection and distribution of information concerning preventable diseases throughout the province.
- (vii) Maintenance of the safety and quality of water supplies and controlling the character of the disposal of human waste for all communities of the province.
- (viii) Establishment and enforcement of minimum standards for food supplies.
- (ix) Provision for services to aid industry in the study and control of health hazards due to occupation.
- (x) Prescription of qualifications for different types of public health personnel.

### **The Provincial Health Board**

21. The functions of the Provincial Health Board will be similar to those of the Central Health Board, namely, the formulation of health policy for the province as a whole and the making of recommendations in respect of the grants to be sanctioned by the Provincial Government for health schemes in local areas. Until the health organisation proposed by us covers the whole area of individual provinces there will be, in each district, certain areas served by the new health services while the remaining parts, which will gradually diminish, will be served by the existing health organisations. For the areas under our scheme we are proposing, as will be seen later in this chapter, a special local health authority which should be designated the District Health Board and should take over the health functions of all existing local bodies in such areas. In the circumstances, during the short-term, representation on the Provincial Health Board will have to be found for the Provincial Government, for District Health Boards and for local bodies, rural and municipal, operating in the areas outside our scheme. When the long-term programme is completed, the jurisdiction of the District Health Boards will cover the whole province, and local bodies constituted under the self-Government Acts, will have ceased to function as health authorities. Representation for local bodies on the Provincial Health Board will, therefore, become unnecessary.

### **The Provincial Health Council**

22. The composition and functions of this council will be similar to those of the Central Health Council.

One of us (Mr. P. N. Saprú) holds somewhat different views regarding the constitutional aspects of the proposals set out above and certain other matters. His Minute is attached to this chapter.

## **HEALTH SERVICES CENTRAL AND PROVINCIAL**

23. We may now proceed to examine the functions of the health services that will be associated with the Ministries of Health at the Centre and in the Provinces. Their main functions are given in diagrammatic form in Appendices A and B to Chapter III of this volume of the report. In addition to the administrative officers in each case there are provided six Deputies at the Centre and five in the Provinces, each being in charge of a special group of subjects. At the Centre we have included town and village planning as part of the functions of the Ministry of Health while, in the Provinces, where

the main developments in this connection will have to take place, we have suggested the creation of a separate Ministry for dealing with the subject (*vide* Chapter XII). The various functions allotted to the Deputies have been distributed among 14 Assistant Directors General or Assistant Directors as the case may be at the Centre and in the Provinces. The distribution of these Assistants in relation to subjects is the same in both cases and is shown below :

	No. of Assistant Directors or Directors General
General Administration . . . . .	1
Medical Relief . . . . .	2
Public Health . . . . .	6
Professional Education and Research . . . . .	2
Public Health Engineering . . . . .	3

24. We realise that certain provinces with larger territories and populations will require a larger directing staff at their headquarters than others. In the circumstances the above figures are offered as tentative suggestions, which individual provinces will no doubt modify to suit their own requirements. It is recognised that officers with adequate experience and training may not be available at once in sufficient numbers to fill these posts in all the provinces. There will, no doubt, be some delay in setting up these organisations in their completed form. Such delay should be minimised as far as possible because it is on the efficiency and proper functioning of these officers, who will be responsible for organising the health scheme which we have recommended, that the success of the programme will largely depend.

25. We have already referred to the importance of securing for the posts of the Director General of Health Services at the Centre and of the Directors of Health Services in the Provinces, persons best fitted to fill these very responsible positions. The qualifications that are necessary are professional and administrative ability of a high order as well as a community outlook which will enable them to view the problems of health not only in relation to their technical implications but also in relation to their bearing on community life. From the professional point of view they should combine experience of the remedial and preventive branches of medical practice. This requirement should easily be met after our health programme has been in operation for fifteen or twenty years, because our proposals require that the same doctor should perform both these functions. The two departments have, however, been working separately in India in the past and it may not, therefore, be easy to secure in the immediate future suitable officers with administrative experience in both branches of health work. We consider that special emphasis should be laid on the possession of community outlook in the selection of incumbents for these posts. As a general rule, it is work in the preventive field that brings a medical man more in touch with the social aspects of medicine. Moreover, he is compelled, from his day to day experience, to look on disease as a community phenomenon, while his colleague on the curative side may often develop a more restricted point of view, because his field of experience may be limited to the care of individual patients. We, therefore, feel that there is some justification for laying emphasis on experience in preventive health work as an important qualification for selection. At the same time we are not oblivious to the fact

that the social outlook, which we have stressed, is not purely the result of service in any particular sphere of professional activity. The development of the community outlook is largely influenced by such factors as a high level of general culture, a background of moral and ethical ideas and a close association with social service activities. In these circumstances, we can do no more than suggest that all the considerations set out above should be taken into account when making appointments to these posts. The same consideration should guide the selection of officers for administrative posts in the district.

### **Recruitment and Control of the Central and Provincial Health Services**

26. We have given considerable attention to the questions relating to the recruitment and control of the future Central and Provincial health services. We recommend that the following principles should guide the authorities concerned with the recruitment and control of these services in India:—

(1) there should be separate and independent Central and Provincial health services appointed and controlled by the Central and Provincial Governments respectively. In our view acceptance of the principle of provincial autonomy militates against the creation of a service the ultimate control over certain members of which may lie outside the jurisdiction of the Provincial Government. Hence it is that we recommend that the Central and Provincial Health Services should be independent and separate;

(2) the venue of recruitment of all these services, Central and Provincial, should be India;

(3) the posts under both the Central and Provincial Governments can be divided broadly into two groups, namely, (a) those which belong to the general health services and the large majority of the posts in teaching and research institutions in respect of which recruitment will be restricted to persons living in India and (b) a small number of posts in connection with teaching and research institutions, recruitment for which may perhaps be necessary from outside the country.

Recruitment to these two groups of posts should be regulated as under—

- (i) As regards the first of these, recruitment should be through the Public Service Commission of the Central or Provincial Government as the case may be. There should be an examination which will include a written test and a *viva voce*.

We recognise that, for various reasons, Governments in India will probably continue to recruit their health and other services, at least partly, on the basis of communal representation. We have dealt with this subject in connection with the admission of students to training institutions and have recommended that a certain percentage of the seats should be reserved for admission solely on merit. As regards recruitment to the health services we attach the greatest importance to certain posts, such as those in teaching and research institutions, being filled only on merit. The former are concerned with the production of health personnel and the latter with the advancement of knowledge for the promotion of health and the conquest of disease. In our view considerations of efficiency

demand that merit should be the sole criterion for appointments to these posts. We also consider that recruitment to a certain proportion of posts even in the general health services should be based on merit, and we recommend that the proportion so recruited should be  $33\frac{1}{3}$  per cent. In filling up the remaining  $66\frac{2}{3}$  per cent. of the posts consideration may be given to the need for communal representation. Every community should have its share of this  $66\frac{2}{3}$  per cent in accordance with the proportions laid down by the governments concerned. We suggest that, of the candidates available from individual communities, the best should be chosen. After admission into the health services promotion to higher posts should be regulated solely by merit. Communal considerations should not have any place here. If they do, efficiency is bound to suffer and the morale of the health services will be lowered.

- (ii) For teaching and research posts in which recruitment in the world market may have to be resorted to, we recommend that the decision should be preceded by a search through the country to secure suitable persons of the required calibre. Experts obtained from abroad should be entertained strictly on short term contracts, extending from three to five years in the first instance.

In such cases, every effort should be made to train a suitable Indian within the period of the contract.

As regards teaching and research posts under Governments for which candidates will be recruited from the world market, their respective Public Service Commissions should be entrusted with the task. It may be found necessary to provide these Commissions with the assistance of *ad hoc* Committees in the countries from which recruitment is contemplated.

(4) We have recommended the creation of independent health services by the Central and Provincial Governments. The successful development of our health programme postulates the closest possible co-operation between the Centre and the Provinces not only through the Central Board of Health but also through the contacts that the administrative and technical officers of these governments will establish with one other. It is, therefore, advisable that the officers of the two types of health services should have adequate opportunities of learning one another's health problems. We recommend that a programme of exchange of officers between the Centre and the Provinces may be planned after mutual consultation. The period of deputation may be about three to five years. Each Government should send to the other a panel of names from which would be selected the required number of officers for mutual exchange. The desirability of exchange at two or three levels in the Central and Provincial Services is stressed. Such exchanges will ensure that officers of varying service and range of experience will be benefited by the proposed scheme.

(5) We assume that the larger financial resources of the Central Government will enable it to maintain a cadre of health officers with higher technical qualifications than most Provincial Governments can afford. Any scheme of exchange is not likely to prove workable if the level of efficiency of the officers from individual provinces is far below that of the officers of the Central Health Service. We therefore suggest that at least a proportion of the posts in the Provincial Cadres should be maintained at a level in respect of salary and

status corresponding to those of the Central Service. This proportion may be filled partly by promotion and partly by direct recruitment.

We consider it essential that, as the vast majority of the members of the Provincial Service will have to enter it through posts on the lowest scale of pay and as merit should be the criterion for promotion, the highest posts in the service should be open to all. By periodical assessments of quality, either through departmental examinations or other tests, it should be possible to select at successive stages of service, capable and keen workers who should be given all opportunities to improve their technical efficiency and to rise in service through efficient work. This being our view our proposal for a percentage of direct recruitment to the superior grade has not been made with the idea of limiting opportunities of advancement for the junior workers in the service. There are bound to be, in an organisation of the type we envisage, certain posts for which persons with qualifications definitely above the usual standard or of a special character may have to be recruited. We have in mind certain technical posts in general health administration, which require special qualifications, and some of the higher teaching and research posts. Persons recruited to such posts are not often likely to be of the age at which people generally enter the health services. Their higher age and wider experience would naturally merit a better starting pay than that provided for those who enter the service in the usual way.

(6) The Central and Provincial health services should be maintained as purely civil organisations. The question of provision of medical services for the Defence Forces is not being dealt with by us as we consider that this subject does not fall within our terms of reference.

(7) All members of the health services, Central and Provincial, should have opportunities of gaining experience of both urban and rural health work.

(8) We recommend that there should be no reservation of posts, either under the Central or under Provincial Governments, for the Civil branch of the Indian Medical Service through rules made by the Secretary of State for India under Section 246 of the Government of India Act, 1935, or under the provisions of any other enactment for certain special categories of that Service.

It is understood that one of the reasons for such reservation is the desire to provide medical aid by British personnel to the British members of the civil services in this country and to their families. Presumably such a demand could not have been made on the basis of racial prejudice. If the claim is based on the idea that the British doctors in India are professionally superior to their Indian colleagues we cannot accept this suggestion. In fact, we maintain that, in all the larger urban centres, many Indian members of the independent medical profession and of the State medical service provide professional ability of the highest type. Even in rural areas it should be possible to arrange for efficient service for British Officers and their families from medical men, British or Indian, from the nearest urban centre. Under the circumstances, the continuance of a reservation of posts on this ground seems unjustifiable.

There are other reasons also for discontinuing such reservations without delay. Reservation of posts in the Provinces for the



members of the Central Service is against the principle of provincial autonomy in as much as it compels Provincial Governments to accept officers whose ultimate control is vested in the Centre and not in the Provinces. We have envisaged a Provincial Ministry of Health responsible to the people of the Province and practically independent of the Centre in the shaping of internal health policy. In our view, therefore, the granting of power to the Centre to thrust its officers on a Provincial Government cannot be justified. We believe that the continuance of this practice will jeopardise the success of our scheme by creating unnecessary friction between the Centre and the Provinces. It should, therefore, be discontinued as early as possible.

We also feel that the principle that merit should be the criterion of selection, makes it undesirable that the practice of reserving posts, either at the Centre or in the Provinces, for the members of a particular service should continue. We envisage the pooling of all available talent in the furtherance of our scheme and its utilisation to the best advantage and this, we feel, cannot be ensured unless the practice of reservation of posts ceases to operate.

27. Two of our colleagues (Drs. Vishwanath and Butt) do not agree with our views regarding a Central Ministry of Health and Central Health Services and also the method of recruitment to Provincial Health Services. We give below their views in their own words:—

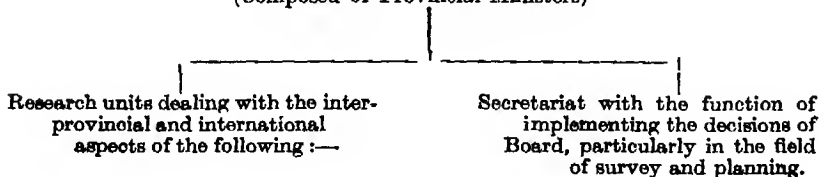
“The highest level of functioning of the health administration must reside where the highest level of autonomy obtains. In India the Central Government is not constituted on a basis of democratic responsibility. At present the Provinces alone possess that level of responsibility which can provide popular sanction for the contemplated schemes of reconstruction and for an administration sensitive to scientific as well as democratic requirements. We are therefore opposed to the creation of a Central Ministry of Health and its administrative apparatus of Central Services. For the disposal of matters of interprovincial and international interest we propose the creation of a Central Board of Health, composed of the Ministers of Health of different Provinces and comparable authorities from the administrative units which are now under the Government of India.

“We also envisage that the Board will take an important part in the promotion of research. In addition to the Secretariat of the Central Board we consider it essential to organise units, under the aegis of the Board, which will function in the field of research in subjects of interprovincial and international interest and reciprocity.

“The proposed organisation is represented diagrammatically below:—

#### CENTRAL BOARD OF HEALTH

(Composed of Provincial Ministers)



- (a) medical relief and public health ;
- (b) the engineering and industrial aspects of (a) above ;
- (c) social aspects of (a) ;
- (d) biological products, including standardisation ;
- (e) biostatistical studies and
- (f) such other functions as the Board may decide to undertake.

"We deprecate the idea of direct recruitment to a superior class in any health service and stress the need for every one entering at the bottom and working his way up through merit. Further, in order to provide sufficient incentive to do good work, even the highest post should be open to the man on the lowest rungs of the ladder. By two tests at the end of the first five and ten years of service respectively, it should be possible to select those who will be promising material. These men will constitute the field of selection for the higher posts in the spheres of administration, teaching and research.

"In the disposal of the highest administrative posts in the provinces we consider it advisable for the appointing authorities to act in consultation with the Central Board of Health. At this level it may be advantageous to Provinces, on both administrative and political grounds, to be free to exchange between themselves this category of personnel. This exchange must, however, be in all cases voluntary and the provision should in no way operate to the detriment of provincial autonomy."

We are in full agreement with the emphasis laid by our colleagues on the principle that merit should be the sole criterion for promotion and that those "on the lowest rungs of the ladder" should be able, through merit, to climb to the highest posts in the different branches of the health service. If our proposals are carefully examined it will be seen that they make definite provision for the application of this principle. As regards direct recruitment to a "superior class" in a provincial health service, we have given full reasons for our recommendation that a proportion of posts in such a class should be filled by this method. Further, we have made it clear that a proportion of these superior posts should be filled by promotion which will be regulated by merit.

29. We further consider their proposal that there should be no Central Ministry of Health and no Central Health Service unsound and impracticable. The main reason advanced by them for this proposal is that the Central Government is not, at present, responsible to the people. We have also recognised this and have, therefore, stressed the paramount importance of establishing the Ministries of Health both in the Provinces and at the Centre on the basis of responsibility to the people, so that the shaping of health policy and its implementation will throughout be influenced by public opinion. We, therefore, feel that there is no fundamental difference between our views and those of our colleagues on this particular matter.

30. We consider their proposal impracticable for more reasons than one. A Board consisting of the Provincial Ministers of Health and its Secretariat cannot function as the administrative machinery responsible for the internal and international health functions which the Central Government will have to perform. We envisage, so far as the country's internal administration is concerned, certain exceptional circumstances requiring the Centre to intervene in the

administration of individual Provinces in the interests of the country as a whole. Action in such cases may often have to be taken expeditiously and a committee which will have to be assembled from all parts of the country is not calculated to meet this requirement. Further, it is doubtful whether effective action will be taken by a collective body like the Central Board, especially if the offending party or parties happen to be the more important among the Provincial Governments. As regards India's international health obligations the Governments of other countries can deal more satisfactorily with a Central Government, which will reflect India's views as a whole than with a Board of Provincial Ministers.

31. Our scheme envisages a Centre acting with imagination and sympathy in its dealings with Provincial Governments in full consultation with them and promoting health development in their territories through grants-in-aid from Central funds and the loan of trained personnel to Provinces, whenever such help is needed. The proposal of our colleagues would, it seems to us, remove the possibility of such help to the Provinces.

### **LOCAL AREA HEALTH ADMINISTRATION**

#### **Local Authorities and Their Present Health Functions**

32. When, in the eighties of the last century, municipal and rural health authorities were established in British India it was decided that various local administrative functions, such as those relating to rural education, dispensaries, sanitation, water supply, drainage and veterinary service should be transferred to the newly constituted authorities. Till the end of the second decade of the present century, these local bodies were under varying degrees of control and guidance by the district officials of Provincial Governments. The Montague-Chelmsford Report (1918) on Indian Constitutional Reforms emphasised the need for a relaxation of such control and they recommended that "There should be, as far as possible, complete popular control in local bodies and the largest possible independence for them of outside control." In accordance with this recommendation, the direct supervision exercised by district officials was withdrawn to a large extent and local bodies were constituted as organisations composed of elected members with a large measure of independence. The results of this transfer of power were not satisfactory because lack of experience and continual pressure from the electorate and from the members of the local bodies themselves made it impossible for the elected Chairman, in whom administrative powers were concentrated, to carry out efficiently the functions entrusted to them. These results might have been in part due to the fact that health consciousness had not been developed to any great extent. Another contributory factor may have been the fact that the supervision exercised by Provincial Ministers of Local Self-government over these local bodies was far from satisfactory. In their review of local self-government the Indian Statutory Commission (1930) stated:—

"The result of the legislative and administrative action taken in accordance with the scheme of the Reforms was, in effect, to deprive the new ministers of local self-government of powers which were essential if they were to perform their tasks successfully. We have heard the criticism that the only effective powers possessed by

provincial governments, namely those of suspension and dissolution, have left the ministers powerless in the face of misconduct calling for less drastic treatment, and we think that the criticism is well founded.\*

33. The Government of India Act, 1935, which came into operation in 1937, made the Provincial Government directly responsible to the Provincial Legislature. Under such conditions in more than one province it was seen that the Ministers were anxious to ensure a raising of the standard of administration of local bodies. In the United Provinces and in Sind special Committees were set up by the Provincial Governments concerned to report on the administration of local authorities.\* We do not know what action was taken in these provinces on the recommendations of their respective Committees.

34. Another instance may also be given. In Madras the Provincial Government has introduced many administrative and legal measures in order to improve local-body administration. Details regarding the action taken by the Government of Madras are given in Appendix 26. Such action has been based partly on the provisions of the Local Self-government Acts governing the local authorities for municipal and non-municipal areas and partly on a consolidated Public Health Act which was passed by the Provincial Legislature early in 1939, when a popularly elected government was in power. Briefly stated, the result was that the relationship of the Provincial Director of Public Health and of Health Officers to local authorities was changed. Previously, these officers were only advisers to local bodies and statutorily they had no executive functions. Rural and urban Health Officers could not, even during an emergency like an outbreak of cholera, employ additional staff or incur expenditure in other directions without the sanction of the Chairman of the local body concerned. All the executive powers were vested in the Chairman, and Health Officers could exercise only such powers as were delegated to them by the Chairman. The Public Health Act has transferred all the executive functions under the various sections relating to health in the Local Self-government Acts and other Acts to the Health Officer. He has been given control over the entire health staff and, during an emergency, he has the power to incur expenditure and to employ additional staff. If his action in these matters is challenged by the local authority, a reference must be made to the Director of Public Health whose decision is final. The latter has also extensive powers under the Public Health Act and these include the power to require local bodies to carry out certain essential measures and power to concentrate Government and local body public health staff in specific areas to meet the demands of special occasions such as festivals and outbreaks of epidemics. Other measures taken in Madras Presidency to improve the administration of local bodies include the provincialisation of the services of health officers, engineers and executive officers employed by these authorities, so as to attract and keep suitable men for these services and thus improve local administration.

### OUR PROPOSALS

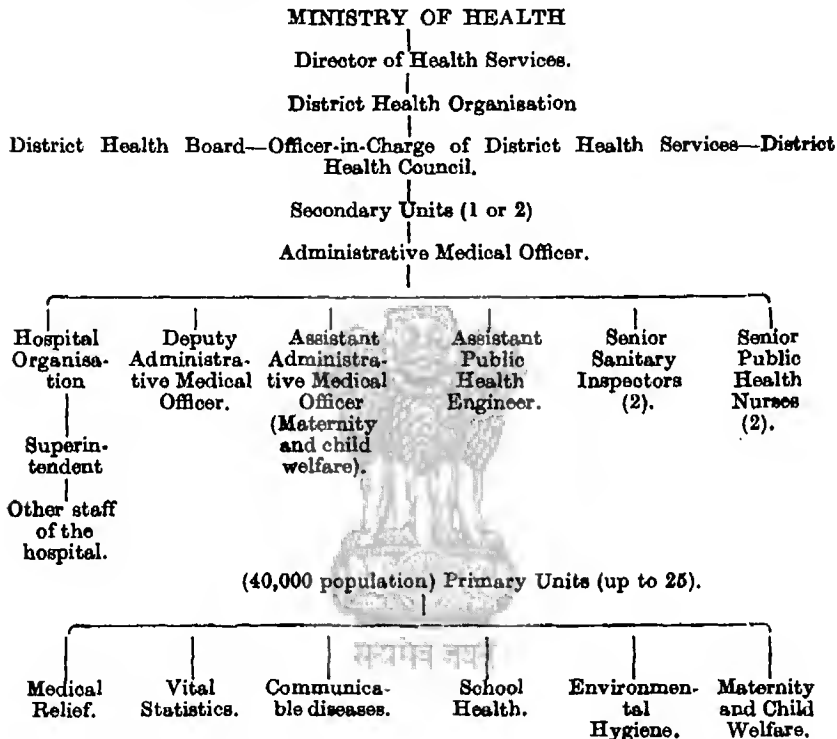
35. In chapters III & IV we have set out our recommendations for the district health services for the long and short-term programmes. Under the latter the new health services will cover only

\*Report of the Local Self-government Committee, United Provinces (1940).  
Report of the Local Self-Government Committee, Sind (1943).

a part of individual districts, the existing services continuing to function in the remaining areas. In view of the general low level of efficiency of local body health administration the first essential is, we consider, an effective improvement of such administration throughout the district.

### The Area Under Our Scheme

36. The following diagram shows the short-term district health organisation proposed by us :—



37. Our scheme envisages a comprehensive health service and the results achieved by it will depend on the fulfilment of the following conditions :—

(a) recruitment of the staff and their conditions of service should be on similar lines throughout the province so as to facilitate the enforcement of fairly uniform standards of performance over the whole area and

(b) there should be continuous and effective supervision by the higher technical staff over the work of the health personnel employed even in remote villages.

38. We consider that these conditions can be secured only through a health service maintained by a single health authority for the whole area under the scheme and not through a number of separate services maintained by different local bodies, municipal and rural, which are now functioning in that area. This raises the question of depriving self-governing units of the health functions which they have enjoyed for sometime past. The question for decision is whether the provision of adequate health services for the people or

the retention of the existing form of local self-government in the area concerned should be our first consideration. We have no hesitation in coming to the conclusion that the provision of health protection to the people should take precedence over the continuance of any specific form of local self-government. We are not, at the same time, oblivious of the fact that the success achieved by any health organisation will depend largely on the degree of support and co-operation that can be secured from the people for whom the health measures are intended. Provision for enabling local public opinion to influence health policy therefore seems to us essential. If this principle can be incorporated in the proposals we put forward for local health administration, we feel that the purpose in view will have been served and that any change from existing forms of local self-government, which may become necessary in order to improve the quality and extent of health service that can be made available to the people, is of secondary importance.

### **The District Health Board**

39. We have already suggested that, so far as health is concerned, in the place of the existing multiplicity of local health authorities with their separate staffs, there should be a single health authority over the whole area operating through a unified executive staff. Such an authority would, we believe, be able to establish a more efficient service by avoiding the duplication of staff and institutions inevitable under existing conditions and through the larger financial resources that would become available to it in view of the wider limits of its jurisdiction. We recommend that this health authority may be designated the District Health Board as its jurisdiction will, in due course, extend over the district as a whole except for certain large municipalities to which reference will be made presently. To this Board should be transferred all the health functions now exercised by the different local bodies included in the area under our scheme. The local bodies will then be left with such functions as education, public works and communications.

40. The composition of the District Health Board may now be considered. Its main function, as in the case of the Central and Provincial Health Boards, is to associate public opinion with the formulation of health policy and with its implementation. Representation of the people on the Board can be secured (1) by direct election, (2) by election, from their own ranks, by the local bodies in the area covered by our scheme and (3) by a combination of both these methods. We are ourselves in favour of the last of these three courses. We also recommend that the District Collector or the Deputy Commissioner as the case may be, should be a member of the Board. His administrative experience and contacts with other departments of Government, the activities of which have a bearing on health, will be of value to the Board. We go even further. We look to him as the official administrative head of the district to secure for the health services, which we contemplate, the active support of the officers of the various departments in the district whose co-operation is essential if advance on a broad front is to be ensured.

41. The functions of the District Health Board will include the discussion and formulation of health policy and the distribution of funds for the different branches of health administration within the area under its charge. We recommend that each local authority

should be required, by a statutory provision, to contribute a fixed proportion of its revenues to the District Health Board. We commend for the earnest consideration of Provincial Governments the ratios that have been laid down by the Madras Legislature in Section 127 of the Madras Public Health Act, 1939. It provides that every municipality "shall earmark not less than 80 per cent. of its income from all sources other than Government grants, for expenditure on the advancement of public health in its local area, including expenditure on medical relief, and every district board or *panchayat* shall similarly earmark not less than 12½ per cent. of its income from such sources." These proportions of their revenues should be made over to the District Health Board by the rural and municipal local authorities in the area. Obviously the actual amount of the contribution in each case will depend on the proportion of the population under the local body concerned which is brought within our scheme. Such contributions and the grants that may be sanctioned by the Provincial Government will together constitute the funds which will be administered by the Board.

42. While the Board will be subject to such rules as may be framed by the Provincial Government for the conduct of its business, it is recommended that there should be a large measure of autonomy in order to ensure that local opinion in the district may increasingly influence health policy and secure public support for it. Nevertheless, the exercise of this autonomy should not be allowed to result in a material departure from the general health policy laid down by the Provincial Ministry of Health or in any serious neglect of the Board's functions to the detriment of local health administration. To meet such contingencies, we may make two suggestions, (1) that the Provincial Minister should have the power of ensuring compliance, by the Board, with the general health policy laid down by him, and (2) that certain legal provisions that exist in the Province of Madras enabling the chief administrative officer of the Public Health Department to recommend specific action by local health authorities in particular directions for the improvement of the public health and to enforce the carrying out of such recommendations, subject to the concurrence of the Provincial Government, should be made applicable to all the areas under our scheme. Reference is, in this connection, invited to Appendix 26.

43. The acceptance of this dual principle of encouraging the growth of local responsibility in health administration and of ensuring, at the same time, the maintenance of a reasonable level of efficiency appears to us to be essential to the success of the comprehensive programme of health development that we have advocated.

#### **Extension of our District Health Board proposal to other functions of local authorities**

44. The main functions which local bodies now perform are those relating to (1) health, (2) education and (3) public works and communications. We have already suggested that the health functions of the local bodies, in the area under our scheme, should be transferred to a District Health Board which will be, to a large extent, popularly elected. While it is not within our province to make recommendations in regard to such subjects as education and communications, we look forward eventually to the establishment of similar boards for the district as a whole, dealing with each

of these subjects. In order to secure coordination of their activities there might well be established a Coordinating Committee on which these organisations will be represented.

### **Larger Municipalities**

45. While we recommend that, eventually, the jurisdiction of the District Health Board should normally extend over the district as a whole, we believe that certain large municipal corporations, which are governed by their own Acts (as apart from the Municipal Acts which are applicable to municipalities in general in the provinces) may be expected to develop and maintain their own health services on the general lines suggested by us (*vide* appendix 27), and that they need not, therefore, be brought into the district health organisation. Examples of such corporations are Calcutta, Bombay, Madras and Karachi. They have sufficiently large populations and sources of taxation to justify their being left to develop separate health organisations. We believe that municipalities having a population of at least 200,000 may also be brought into this category provided they are in a position to maintain an independent health service of the required technical efficiency. Population is not, however, the only criterion. The financial resources of the municipality, including such grants as it normally receives from Government, should be sufficient for the maintenance of the required health services. A decision as to whether a municipality falls into this category can be made only by the Provincial Government concerned in the light of their knowledge of local conditions.

46. In making this recommendation, we have been influenced by the consideration that we should limit the deprivation of the health functions exercised by municipalities only to such as are in our opinion unlikely to be able to maintain the standard of service we have recommended.

47. The large municipal corporations which are governed by their own acts, will be responsible for the maintenance of the local health services which should not fall below the level of those recommended by us in our three-million plan. This leaves for consideration other large municipalities with a population of 200,000 and over. The organisations recommended in our scheme for the headquarters of a secondary unit and of the district may sometimes have to be located in such municipalities. In such cases, these organisations will serve the needs not only of the local municipal population but also of the inhabitants of a wider area. In the circumstances we suggest that the Provincial Government should meet the cost of the creation and maintenance of these institutions and recover a suitable contribution from the funds of the municipality concerned. Should, however, a municipality of this class desire to provide itself with its own health services and should it be prepared to find the necessary funds, it should, of course, be allowed to do so. It is essential, however, that the Provincial Government should ensure the due fulfilment of the health functions entrusted to all municipalities.

### **The Area Outside Our Scheme**

48. While recognising the need for raising the existing level of efficiency of health administration we do not propose that the local bodies in such areas should be deprived of their health functions. We, however, consider it essential that in these areas action on the



lines taken in the Province of Madras to improve the health administration of local bodies should be adopted in other provinces (*vide* Appendix 26).

### **Recruitment and Control of the District Health Service.**

49. A question of fundamental importance in regard to the recruitment and control of the district health service is whether these should rest with the Provincial Government or with the District Health Board which we have suggested. We have considered this question very carefully and have come to the conclusion that the balance of advantage is heavily in favour of the provincialisation of this service. Our reasons for coming to this conclusion may be briefly stated:—

(1) Local area health administrations, which possess restricted resources, may often find it difficult to recruit persons of the required calibre because they cannot afford to offer attractive salaries, though it may frequently happen that the poorer areas may be most in need of efficient officers. Provincialisation of the district health service will render it possible to ensure that health personnel of the required quality are made available to areas where their services are most needed.

(2) Service in certain areas may be so unpopular for climatic and other reasons that only a provincialised service can ensure the provision of adequately qualified staff for such areas.

(3) In a provincialised service, the health staff will have more opportunities for widening their experience through contact with varying conditions in many areas than service under a single district health authority could afford.

(4) Under a provincialised service, a member of the health staff, who cannot work harmoniously with a particular District Health Board, can be given a chance of proving his capacity to render satisfactory service by a transfer to another district.

(5) On special occasions, such as festivals or outbreaks of disease, the Director of Health Services will, with a provincialised service at his disposal, be in a position to concentrate staff from other parts of the province at places where their services are most urgently needed.

(6) The securing of a fairly uniform standard of performance throughout the province would become easier with a provincialised health service than with independent health staffs under different District Health Boards with their varying standards of recruitment and conditions of service.

(7) In the provinces, which have had provincialised services of health officers for a number of years, the results achieved have been satisfactory from the point of view of the Government as well as of the local authority.

50. In our view, provincialisation need not necessarily mean that the expenditure on the whole organisation should be borne by the Provincial Government. We understand that, in the province of Madras, 25 per cent. of the average pay of Municipal Health Officers is recovered by that Government from the municipalities concerned, although the posts have been provincialised.

51. An important question for examination is, whether the whole of the district health staff should be provincialised or only a part of it. From the point of view of efficiency, we recommend that all the

members of the health organisation should be provincialised. If only a certain number of the more responsible posts are provincialised and the others are left under the Board, the resulting dual control must, we believe, lead to inefficient administration. We, therefore, recommend that the whole district health service should be provincialised in the areas under our scheme.

52. We shall next refer to the position of the Officer in charge of the District Health Service in relation to the District Health Board. Under our proposals he will be a provincial officer whose services are lent to the Board. He should be responsible for carrying out the health policy laid down by the Board and we recommend that he should be its Secretary. In this capacity, it will be possible for him to assist its decisions on health matters by his technical advice. While his position as a member of the Provincial Health Service will give him a measure of independence in expressing his professional views, he cannot carry on the administration successfully without securing the fullest possible cooperation of the Board, which will have to approve his schemes and provide money for them. We believe that this relationship between him and the Board will help to promote cooperation and to build up conventions which will serve to demarcate the respective spheres of activity. We anticipate that such close association between him and the Board will be of value to both.

53. Nevertheless, a state of affairs may arise when the Officer in charge of the District Health Service and the Board cease to work together harmoniously. If such a stage is reached, this Officer cannot usefully continue in the district. We, therefore, recommend that, if the Board passes a resolution by a two-thirds majority (taking into consideration its full strength) asking for his removal, the Provincial Government should transfer him from the district. We have recommended that this resolution demanding the transfer of the Officer should secure the support of two-thirds of the sanctioned strength of the Board in order to ensure that the request would not be lightly made.

54. In Chapter IV we indicated how the new health services covering only a portion of individual districts during the short-term programme should be integrated with the existing organisation. We recommend that the curative and preventive departments of health working in a district should be unified under one administrative officer to be designated Officer in charge of District Health Services. He will be responsible, during the short-term, for promoting the development of the new scheme as well as for maintaining the existing services in the remaining parts of the district. The administrative officers in charge of secondary units, who will co-ordinate curative and preventive work in their own areas, will serve as assistants to the Officer in charge of the District Health Services. During the first five-year period, there will be only one secondary unit and, therefore, only one deputy while, during the second five years, there will also be a second deputy in many districts in the different provinces.

#### **District Health Council**

55. We have already recommended the creation of a District Health Council consisting of representatives of the different professions (*e.g.*, those of doctors, dentists, pharmacists etc.) from the

registered members of which the health service will be recruited. The functions of the Council will correspond to those of the Provincial and Central Health Councils. We recommend that the Officer-in-charge of the District Health Services should be the Chairman of the Council.

56. An important function of the District Health Council will be to secure the support of the independent medical and ancillary professions to the development of the health programme. We consider this particularly necessary in the earlier stages. In the larger urban centres, an independent medical profession of standing has been developing during recent years. The informed and constructive criticism of its members should prove of value in the shaping and functioning of the health services. It is suggested that schemes involving technical questions should be submitted to the Health Board with the recommendation of the District Health Council. Its function will be purely advisory, as the ultimate power to define policy and vote funds will be vested in the District Health Board. Even so, the views expressed by the Council are not likely to be turned down by the Board without good and sufficient reasons.

57. The question may be asked as to whether, in our scheme of national health service which we anticipate will eventually develop into a full-time salaried service covering the whole population, there is room for the proposed Health Councils at the three levels of administration, the Centre, the Province and the district. When this stage is reached there will probably be no need for them. But through the many years of development these Councils will, it is anticipated, perform a useful function.

58. One of us (Mr. P. N. Sapro) holds views which are different from those expressed above regarding the provincialisation of the services under local authorities. He has embodied his views in a note which is appended to this chapter. He agrees with us in recognising that it is essential to ensure security of tenure and fair treatment to the servants of local authorities if efficiency is to be maintained. He, however, does not approve of provincialisation as the method of securing this end. He thinks that provincialisation is likely to lead to friction between local bodies and the public servants who have to work under them. His proposals fall under three heads:—

1. He advocates the creation of a Local Government Board which will function in an advisory capacity to assist the Minister of Local Self-government in his task of controlling the administration of local bodies in the province. The Chairman of the Board will be the Minister of Local Self-government. The members will consist of a certain number of Ministers who deal with such portfolios as education, public health, labour, co-operation etc., elected representatives of municipal and district boards, representatives of medical and engineering professions, of universities, Chambers of Commerce and Trade Unions as well as a certain number of persons nominated by the Minister of Local Self-government to represent interests, which may otherwise go without representation on the Board.
2. All grants given to local bodies by the Provincial Government will be sanctioned after taking into consideration the advice given by this Local Government Board. The

principal administrative officers of Government will be responsible for supervising and inspecting the administration of local bodies. Grants can be withheld if they are not utilised in accordance with the policy laid down by the Board.

8. In order to provide for security of tenure he suggests the creation of a Local Self-government Public Service Commission which should be established by an Act of the Provincial Legislature. The Commission would consist of a Chairman nominated by the Minister of Local Self-government and of two other members also appointed by him. All appointments including that of sanitary inspectors under local bodies will be made on the recommendations of special Appointment Committees, which will consist of one of the members of the Local Self-government Public Service Commission and two members selected by the local body for which the appointment in question is being made. The Appointment Committee will send three names in order of preference to the local body which will be required to select its candidate from these three names. The appointing authority will be the local authority. It will also have the right of transferring, censuring and even dismissing its servants but, in every case, a commissioner of enquiry should precede such disciplinary action. The affected individual can appeal to the Local Self-government Public Service Commission; the decision of which will be final.

59. We have set out, at some length, the recommendations of our colleague because we feel that they deserve the fullest consideration. Local self-government is, undoubtedly, the instrument through which provision is made in all democratic countries for an expression of the people's opinion on matters vitally concerning local welfare. We share with him his desire to see that the people should be given an opportunity to express their views, through their representatives, on the health services that are to be provided for them. We have, therefore, provided that the District Health Board should have representatives from the local authorities in the area concerned as well as through direct election by the people. We, therefore, feel justified in claiming that the Board, which we have suggested, will be competent to express the people's will and to meet their health needs.

60. We cannot help feeling that the proposals of our colleague are cumbersome and that they are not likely to promote efficient administration. His scheme will perpetuate the existing system of numerous local authorities within a district with their independent health services. Although a certain measure of security of tenure will be conferred on the servants of these authorities by his proposals, we feel that the separate organisations working within their limited areas and with no coordinating agency over them cannot produce the results that we anticipate from the integrated health service we have outlined in the three-million plan. The essence of such a service is supervision by the highly developed technical staff at the headquarters of the district and of secondary units over the work done in even the remotest villages. An organisation of this type cannot be

developed without a single health authority being made responsible for the whole area.

61. Our colleague's main objection to provincialisation seems to be that it will lead to friction between local bodies and the provincial servants working under them. In this connection we have already pointed out that a provincialised service of health officers has been functioning in a number of provinces for many years and the information available to us does not support the view that the system is likely to produce such friction and is, therefore, calculated to function unsatisfactorily. In the Province of Madras, where the provincialisation of different services under local bodies has been extended much farther than in other provinces, our investigations give definite proof that provincialisation has worked well and has increased efficiency in health administration.

### CERTAIN OTHER MATTERS

#### 1. Should Secretaries to the Ministries of Health be technical or non-technical officers?

62. A considerable majority of us feel that in the Secretariat hierarchy, the contact between the Technical Adviser and the Minister should not be broken by the intervention of a non-technical Secretary to Government and that the Director of Health Services, whether at the Centre or in the Provinces, should himself have the status of, and function as, a Secretary to Government. They consider that the person best qualified to assist and advise the Minister on matters so technical is the Administrative Head of the Services concerned and that his contact with, and responsibility to, the Minister should be unfettered and undiluted. The background and experience of the individual who will hold this post, with his intimate contacts with the urban and rural populations with which his previous experience will have provided him, will give him a knowledge of the habits and customs of the people and with their psychology not less than those of a non-technical Secretary, and appreciably more than those possessed by that Secretary if his service has been mainly in the Secretariat. They consider it undesirable and wasteful of time that recommendations on health policy should have to pass through a lay filter, and consider that the wider administrative aspects stressed by the minority would be adequately supplied were the Director General of Health Services provided with the advice of an experienced civil servant in the capacity of his Deputy for administration. In support of this view they cite the increasing tendency of Administrations to appoint as Secretary to the Departments of Engineering and Education the local heads of the Services concerned. Health is even more technical and fundamental than Engineering and Education and these considerations apply with even greater emphasis.

The minority (Sir Joseph Bhore, Pandit L. K. Maitra, Mr. N. M. Joshi and Mr. P. N. Saprú), however, feel equally strongly that a non-technical Secretary to Government, with general administrative experience extending over a wide field, is highly desirable in order to ensure a just and balanced consideration of questions which concern the life and welfare of the community. Measures connected with the health and medical service of the people can never, in this country at least, be matters of purely technical concern and any attempts to isolate them in this way must inevitably lead to disaster.

To the consideration of such measures must be brought a wide knowledge of the habits and customs of the people, their psychology and the administrative system under which they live, and a non-technical Secretary, with experience of the nature we have indicated, is *prima facie* much better equipped to assess and present, for the final judgment of the Minister, the social, psychological, administrative or political background against which public health and medical problems must, of necessity, be so often viewed.

One of us (Sir Frederick James) is not in agreement with either of the two views expressed above. He says, "The majority and minority views are mutually exclusive and I am, therefore, not able to subscribe to either of them. The Governments should be free to select the most suitable person, whether technical or non-technical, for the post of Secretary to Government in the Health Department. If a technical person is selected I agree that it might be helpful to have as his deputy an experienced civil servant; but the senior officers of the health services should be eligible for appointment to the post of Secretary, and if any of them has the requisite experience and ability he should be appointed in preference to a non-technical officer."

63. We are all, however, agreed upon the necessity for ensuring that the Technical Adviser has the right of access to the Minister and that, on a purely technical question, he should be given full opportunity for the exercise of that right before his views are over-ruled. We, therefore, suggest that any adverse criticism of the non-technical Secretary on a proposal put up by the Technical Adviser should be shown to the latter in order to enable him to reply to such criticism. The Minister will then be in possession of all the relevant arguments to enable him to give his decision.

## 2. Salaries.

64. We have been greatly exercised over the scales of salaries to be allowed for in calculating the cost of our proposals. The remuneration of the personnel required accounts for the major portion of the overall estimated recurring expenditure, and while too generous a provision on this account may well wreck or at least grievously handicap the implementation of any large-scale health scheme, salaries inadequate to attract the type of persons needed in the numbers required might have equally disastrous consequences.

65. There are weighty considerations against over-loading the salaries budget. India is a poor country. It cannot afford rates of remuneration which are out of all relation to its national income and are higher than those which economic conditions demand. China and Japan, so far as information is available of prewar conditions there, had grasped this basic fact in relation to their own economy. We have been given instances of the salaries paid to certain medical teaching staff in these countries.

66. At the Peiping Union Medical College which paid higher salaries than any other medical college in China, the following scales of pay for full time workers were in force.

Professor	approximately Rs. 930 a month.
Associate Professor	approximately Rs. 563 a month.
Assistant Professor	approximately Rs. 488 a month.
Associates	approximately Rs. 375 a month.
Assistants (Demonstrators)	approximately Rs. 160 to Rs. 281 a month.

In Japan the following appear to have been the salaries in vogue:—

Principal of a Medical College	approximately Rs. 500 a month.
Professor	approximately Rs. 416 a month.
Associate Professor	approximately Rs. 200 to 300 a month.

We are not in a position to say, however, whether these figures represent the total emoluments drawn in each case. The scales of remuneration of comparable categories in this country vary from province to province. Taking Madras as a basis of comparison, a Member of the I.M.S. in a Professorial post would draw his grade pay *plus* Rs. 250 as teaching allowance. A Lieut.-Colonel would thus draw under the old scale Rs. 1,500 to 1,700 *plus* Rs. 250 and be entitled to private practice. The rates of pay provided for the Provincial Service are for

- (1) Professors (clinical subjects) . Rs. 500 to Rs. 900 *plus* Rs. 150 teaching allowance in each case with private practice.
- (2) Professors (non-clinical subjects) . Rs. 800 rising to Rs. 1,200.

67. In the U.S.A., where the cost of living is presumably much higher than it is in this country or the United Kingdom, salaries of Professors in the clinical subjects are said to vary between 10,000 and 12,000 dollars a year, that is approximately between £2,000 and £2,400. Turning next to other posts, the information given to us in regard to Australia shows that the Chief Medical Officer of the Commonwealth draws a salary of £2,000 (Australian, equivalent to approximately Rs. 1,800 a month). In the United Kingdom, the Chief Medical Officer to the Ministry of Health in 1944 drew a salary of £2,200 per annum. This has evidently been sufficient to attract men of outstanding attainments, for among the incumbents of this post have been numbered some of world-wide reputation. The maxima drawn by Inspectors General of Civil Hospitals, Surgeon Generals, the Public Health Commissioner to the Government of India and the Director General, Indian Medical Service, vary roughly between about £2,475 for the first of these classes and £3,100 for the last named.

68. We are unable, with the material at our disposal, to institute fair comparisons or to venture on any specific recommendations in this behalf. The question of salaries, moreover, is not one which concerns medical and public health personnel alone. It is a much wider and more complex problem. The necessity for establishing some measure of parity between the various Provinces in the matter of the salaries of their Medical and Public Health Services, has been strongly impressed upon us by a Provincial Minister of Public Health on grounds which appear to us to have considerable force. But this is not the only consideration to be taken into account. Any very large disparity between the remuneration paid to the various State Services operating in different fields is to be deprecated unless strong reasons exist for such differences, though we realise that the levels of salaries must be such as will not fail to attract candidates with the qualifications required in each case. The competitive attraction provided by non-State employers is another factor which cannot be ignored.

69. We consider this subject to be of such complexity and importance that it calls for comprehensive examination at the hands of an *ad hoc* All-India Committee which should include medical men.

The results of such an examination cannot fail to be of the utmost value and assistance to the provincial authorities. For our present purposes, we have either adopted existing rates or assumed scales of pay which appear to us *prima facie* to be generally not unreasonable. Our figures will no doubt need revision in the light of a fuller investigation such as we have recommended. On one point, however, we feel that we are on sure ground and that is in laying down the general principle that the salaries of employees of the humbler categories and in the lower grades need to be raised while those at the top may well stand some levelling down.

70. We ought also to make it clear that in those cases in which, in the interests of the country, it is found absolutely essential to obtain a specialist from abroad, the terms offered will have to be such as are necessary to secure the class of person required. Such cases will, we hope, not be numerous. They will, of course, fall outside the cadre of the regular medical services of the country and should invariably be regulated by short-term contracts.

71. While, doubtless, the labourer is worthy of his hire, the most fruitful and inspiring effort must always come from those to whom monetary returns count less than opportunities of service and of advancing the cause of human knowledge. We feel that the world is not bankrupt in such workers and that India may still continue to attract some who do not wish to assess their reward solely in terms of money.

72. Our proposals visualise a very large increase in the number of women doctors in the State Medical Service, and the question of their salaries, therefore, assumes considerable importance. The principle of equal pay for the same work appears to us to be the most equitable.

### 3. Legislation

73. We have already emphasised the need for such amendments of the existing provisions of the Government of India Act, 1935, as will be necessary to enable the Centre to discharge its responsibilities under certain exceptional conditions for safeguarding the health of the country as a whole. In addition to such legislation by the British Parliament, we consider it essential that the existing law relating to health should be revised, modernised and consolidated. Legal provisions relating to health lie scattered through various enactments, and we recommend that the Central and Provincial Legislatures should, within their respective spheres, bring together these provisions and add to or modify them, as may be necessary, in order to provide comprehensive Public Health Acts on which future health administration may be built up.



**Minute on Certain Constitutional Aspects of the Proposals regarding the Relationship between the Centre and the Provinces and on some other Matters by the Hon'ble Mr. P. N. Saprú**

My colleagues have stated that "the principle of autonomy of provinces in health matters, which has been accepted and followed for some time past, should not be set aside unless it can be shown that a reversal of this policy is fundamental to the development of the national health programme". They add that "in a sub-continent of the size of India it seems almost certain that progress on sound lines cannot be made through an administration based on an autocratic Centre which may not secure the active cooperation of the provinces". They emphasise in that "there will be so much opposition to a resumption of control by the Centre that it will become difficult to create and maintain that atmosphere of good will which we consider essential to the success of our scheme". Shortly put, their standpoint is that "the principle of provincial autonomy should be respected to the utmost limit possible consistent with provisions for speedy and active interference by the Centre in circumstances in which dereliction of duty jeopardises the health not only of those under its charge but also of those living in areas outside its jurisdiction".

My close association with my colleagues has convinced me that they are not actuated by any desire to attack the principle of provincial autonomy merely in order to strengthen a Centre which is at the moment irresponsible. For the basic assumption underlying our report is that if India is to plan successfully her health programme, there must be fully autonomous popular Governments both at the Centre and in the provinces to lay down and execute plans. Nevertheless, I fear that some of our recommendations, to which I shall invite attention, are not based upon a full appreciation of the nature of a Federal Constitution upon the principles of which it is impossible for this country to go back. Far from securing full and active cooperation between the Centre and the provinces, they would actually lead to friction and bickerings which might drag health into the arena of controversial politics. They are unworkable both from a constitutional and administrative point of view, and would create avoidable deadlocks between the Centre and the provinces. For these reasons, I have felt it incumbent to record my dissent from the recommendations noted in some of the succeeding paragraphs.

I concur with my colleagues in the view that in existing circumstances, the Centre should help the provinces by grants-in-aid for specific purposes. There is nothing inherently inconsistent with the federal principle in this proposal. The principle of grants-in-aid is not unknown to other federal constitutions. In the United States where the federal principle has worked successfully and where the states enjoy residuary powers, the Federal Government has been aiding by the Social Security Act of 1935, programmes of social reconstruction. In the Australian Act, which is based upon the principle of a federation in which the residuary powers vest in the provinces, the Federal Government has authority, of which it has taken advantage, to help the State Governments with grants for implementing programmes for the development of social services on specific terms and conditions. In India it is obvious that the provinces with their

limited resources will not be able to undertake the health programme as visualised by us. Ultimately, however, the right solution would be to provide the provinces with more elastic sources of revenue than they enjoy at present. It would be unfortunate, however, if the acceptance by the Centre of the principle of grants-in-aid to the provinces were allowed to prejudice their claims for such a revision of the Indian taxation system as would ensure greater justice to them.

But while I agree to the principle of grants-in-aid from the Centre to the provinces, I should like to stress that the financial assistance which the Central Government gives to the provinces should not be used as a lever for whittling down provincial autonomy but utilised for helping social development in the provinces on a coordinated and cooperative basis discussed and agreed to by the provinces and the Centre. The satisfactory working of such a system of grants-in-aid would depend upon the wisdom and cooperation displayed both at the Centre and in the provinces. It is obvious that the Central Government if it aids the provinces with financial grants, shall have to keep itself informed in the discharge of its responsibility to the Central Legislature, of how the purposes for which the grants given are being implemented by the provinces. Equally on the part of the provinces too it will be necessary to carry out faithfully in a spirit of wholehearted cooperation the policies they have agreed to and the conditions on which the grants have been made. If both or either of them feel that the conditions are intolerable, it will be open to both or either to seek accommodation or refuse to accept financial assistance. I have made these observations because as a strong believer in the federal principle for this country I desire to make it clear that I do not wish the system of grants-in-aid to be worked in such a manner as to make it virtually an indirect instrument of controlling the provinces by the Centre. I should also like to add that, in my opinion, the Statutory Board of Health, which we recommend, should be set up at the Centre, would go far to ensure harmonious cooperation and coordination of all health activities in the country. Its advice and cooperation should prove most helpful in determining not only the purpose, for which grants-in-aid should be given but also in ensuring that they are properly utilised.

I shall now proceed to indicate my dissent from those specific recommendations of my colleagues on the relationship between the Centre and the provinces which are unacceptable to me. The first issue on which I differ from my colleagues is their recommendation that the Government of India Act should be so changed as to provide for speedy and active interference by the Centre in cases in which dereliction of duty by a provincial Government jeopardises the health not only of those under its charge but also of the country as a whole. Thus, in enumerating the functions of the Central Ministry of Health my colleagues stress that the Minister of Health should have power to take such legislative or executive action as may be provided by the Constitution as being action in respect of which All-India measures are necessary to safeguard the health of the country.

They specifically recommend in their chapter on Public Health that effective control of the spread of infection among the provinces, and between the provinces and the States, requires that executive officers of the Central Government should be able to intervene in the

enforcement of measures necessary to ensure the active cooperation of all the Central, Provincial and State agencies. In other words, what they recommend is that for the prevention and spread of disease from one area to another, the Government of India should have power to issue orders to Provincial Governments which it can execute through officers under its control. Indeed, they seem to be of the view that the Central Government should have power of active interference in provincial administration not only in the interests of the country as a whole but also in order to protect the health of the province itself.

No case based on any review of the experience gained of the working of the Government of India Act has been made out by my colleagues for this recommendation. The legal position at the moment under that Act is that legislation in regard to the prevention and extension from one unit to another of infectious or contagious diseases of pests affecting men, animals and plants is an item under Entry 30, Part II, List 3 of the VIIIth Schedule of the Act. It is a subject under the Concurrent List which means that the Federal, that is, the Central Legislature can pass equally with the Provincial Legislature, laws in regard to it. The Joint Select Committee have stressed that this concurrent power of legislation should be exercised by the Central Legislature only after previous consultation with the provinces. If a Statutory Board of Health of the nature of an Inter-Provincial Council contemplated by Sec. 135 of the Government of India Act is set up, consultation and coordination of policy between the Centre and the provinces will automatically become much easier. In any case so far as legislation is concerned, the Central Legislature possesses concurrent rights of legislation in regard to infectious diseases. The question whether the Central Government should have any larger powers than has been conceded by the Government of India Act 1935 in regard to the prevention of disease was not a new one before our Committee for it was expressly considered by the Joint Select Committee and Parliament at the time when the Act was passed in 1935. When the Government of India Act was under discussion in the House of Commons, it was suggested, for example, by Sir Francis Fremantle that the Governor-General should have special responsibilities for the prevention not only of any grave menace to the peace or tranquillity of India but also of any grave menace to health. In the course of his speech on February 28, 1935, Sir Francis Fremantle pointed out that "epidemics are liable to flare up suddenly in any one or more of the provinces or states and they run like wild fire across from one end to the other. The early beginnings are unseen and then they get beyond control. There would be no time for the Inter Provincial Council to act as laid down in Clause 133". In answer to this line of criticism it was pointed out by the then Under-Secretary of State for India, Mr. Butler, that public health had been one of the transferred subjects for several years and that it was, no doubt, one of the subjects to which Indian ministers had paid most attention and had responded most readily. He further emphasised that the prevention of the extension from one unit to another of infectious or dangerous diseases affecting man, animals and plants had been deliberately put in the Concurrent Legislative List "partly as arising from the discussions of the Joint Select Committee and partly out of the realisation by the Government of the urgency of the question". He also pointed out that

under what is now Sec. 126 (2), the Central Government had authority to give directions to a province as to the carrying into execution therein of any Act of the Federal Legislature which related to a matter specified in Part II of the Concurrent List. It was also stated by Mr. Butler that provision had been made in the Bill (now the Government of India Act) for the setting up and maintenance of Federal Agencies or Institutes of Research, including scientific and medical research, and that by providing for Inter-Provincial Councils, the constitution was making it possible for some Central Board of Health or machinery to develop.

It is further interesting to recall that it was urged by Sir Herbert Williams and the Duchess of Atholl in Amendments moved to the Government of India Bill when it was under discussion in the House of Commons, that certain aspects of public health, such as epidemic diseases, plague, the movements of insects, agricultural diseases were of nation-wide interest and that public health which knows no frontiers should be either an all-India subject or, at all events, a concurrent subject. In answer to this criticism of the Duchess of Atholl, Sir Herbert Williams and Sir Alfred Knox (all opponents of constitutional advance in India), it was urged by Mr. Butler that "the future of India must be built upon units which are really autonomous. Our service to provincial autonomy is not mere lip service; we realise its deep implications". He went on to stress that "the differences between the provinces as regards the incidence of disease follow, unfortunately, provincial idiosyncracies and that, for example, it would not be conducive to the extinction of Malaria if we were to insist upon regulation by a Central Act of the provincial treatment of Malaria in different parts of India. Further, Mr. Butler laid emphasis on the fact that in order to eradicate disease and have an efficient public health and sanitary service, it was essential to encourage local effort and provincial autonomy in these matters. "We believe", said Mr. Butler, "that interference by the Centre would not encourage local effort, but rather retard it and that we should be taking away from the locality the necessary stimulus to deal with its own particular problems".

I have quoted from Mr. Butler's speech at length in order to indicate that the question of the spread of contagious diseases from one unit to the other did engage seriously the attention of Parliament in 1935 when the Government of India Act was passed and that solutions which aimed at greater interference by the Centre with provincial autonomy in health matters were ruled out at that time for good reasons. Indeed, it was pointed out with great force by Mr. Butler that "in no federation had the problem of health development been solved by coercion from the Centre but always by development of the units". He referred to the example of Australia and said: "The development of public health there arose out of the appointment of the Royal Commission in 1926 and it may be said that as a result of that, further coordination between the different states of Australia has taken place and has finally resulted in the establishment of an Australian Health Council and latterly, I am glad to say, of an actual Department of Health in Australia. That has been arrived at entirely by a process of coordination and cooperation between the units and not by any artificial control from the Centre. In India we envisage that the future will follow very much

the same line, or rather I may be permitted to hope so." Section 135 of the Government of India Act provides for an Inter Provincial Council for the coordination of and cooperation in matters of inter-provincial concern. Advantage can be taken under this section to facilitate the coordination and cooperation between the different units regarding health activities. Similarly under Sec. 103 the Federal Legislature can, if empowered to do so, legislate for two or more provinces by consent. Thus it is clear that ample machinery exists for ensuring cooperation and coordination between all health activities under the scheme of the existing constitution. The recommendation which my colleagues have made, *viz.*, that the Central Government should have power of executive intervention where there is danger of a spread of epidemic, would represent a radical departure from the policy laid down by the Act of 1935 and I can see no justification for it. For what I understand my colleagues to recommend is that the Federal Government should have power to carry out its orders through its own officers, when there is any danger of the spread of infectious diseases from one unit of the Federation to the other. Such intervention would mean supersession of the Provincial Government during a period of emergency so far as health activities are concerned. Action of this nature on the part of the Federal Government may well lead to a constitutional crisis between the Centre and any Provincial Government or Governments. It can lead to a clash resulting in the resignation of the provincial ministry, and this in a country with its present communal cleavages. The necessary consequence of any taking over by the Central Government of the powers vested in the provinces to implement Federal Acts or directions given by the Central Government will be to drag health into political controversies in times of emergency when the utmost cooperation is needed between the Central and Provincial Governments. Furthermore, such a step would completely nullify the authority of the provincial electorate over its own Government, for it is obviously impossible for Provincial Governments to be responsible, in the ultimate analysis, to two different electorates.

To sum up, the position, as I see it, is that under the Government of India Act the power to legislate in regard to the prevention of the extension from one unit to another of infectious or contagious diseases or pests affecting men, animals, or plants is an item under Entry 30 of Part II, List III of the VIIIth Schedule of the Act. Thus the Central Legislature has ample powers of legislation after consultation with the provinces in regard to the ~~sarea~~ spread of epidemics, etc.

Section 126 of the Government of India Act authorises the Federation to give such directions to a province as to the execution in that province of any Central Act as may appear necessary to the Federation for ensuring that the provinces enjoy their authority in such a manner as not to impair or prejudice the authority of the Federation. Sub-Section 4 of Section 126 authorises the Governor-General in his discretion to issue Orders to the Governor of any province which has not carried out any instructions given either to carry out the directions previously given or those directions modified in such manner as the Governor-General thinks proper. Under a system of real responsible Government there can be no question of the Governor-General acting in his discretion. The power to give such directions on the failure of the Provincial Government (for the Governor means

the Provincial Government) will, under a system of real autonomy, reside with the Federal Government. These are vast powers which coupled with the new Sub-Clause 4(a), which is from my viewpoint open to objection, to Section 126 have given a distinct unitary bias in central matters to a Federal Constitution and I cannot understand clearly what further powers my colleagues think should be vested in the Federal Government. If they think that the Federal Government should have power to carry out its orders through its own officers, then obviously such intervention would mean a supersession of the Provincial Government so far as health activities are concerned during a period of emergency. Such action, as I have indicated above, on the part of the Federal Government may well lead to a constitutional crisis between the Provincial Government and the Central Government. From the point of view of health administration itself and the emergent situation which will have to be dealt with, an eventuality like this will be most regrettable. The implication of a federal constitution is that provinces are autonomous within the sphere allotted to them. They cannot be treated as glorified municipalities subject to the superior authority of a Central Parliament elected on issues which have no relevance to those for which Provincial Governments are responsible. There are ways in which, without impinging upon the principle of provincial autonomy, harmony and cooperation between the provinces and the Centre in regard to the prevention of the spread of disease can be secured. In any case, the existence in India of a number of Indian States in which the writ of the Federal Government cannot run until they come into the Federation and agree to the executive authority of the Federal Government running in their States is a circumstance to which insufficient attention has been paid by my colleagues. The main object of their desire to invest the Central Government with such over-riding powers is to prevent the spread of disease from one unit to another. But in the absence of any control over the states, no amount of control over the Provincial Governments, however far reaching, can achieve this object. Is it intended that the Central Government should have power, in the interests of the prevention of disease, to issue orders to the Indian States or impose officers of its own on them? Can it be said that the danger of the spread of disease from states to British Indian provinces is less real than that of its extension from one province to another? If not, how is the problem of intercommunicable disease solved by giving authority to the Federal Government to interfere with the executive authority of the provinces which are legally bound to carry out the directions of any legislation under the Concurrent List? I cannot help feeling that this aspect of the problem has been ignored by my colleagues. Moreover, a further question which remains to be considered in this connection is that of the personnel which will carry out the orders of the Federal Government. We have agreed to the principle that there should be no imposition of central officers on the provinces. We have further agreed to the principle that the provinces should have their own services recruited and controlled by them to carry out health activities. Is it contemplated that when intervention takes place, the Centre will impose its own officials or is it visualised that the provincial officials will cease to be provincial servants for the time being and become the servant of the Central Government? In the former case the Centre will have to keep a reserve of officers who will have no specific duties to perform in normal times and who will thus be a

burden on the tax-payer. In the latter case, provincial officers will be in the very difficult position of serving two masters, one in ordinary times and the other in exceptional times. This may affect their morale. The conclusion to which I am driven is that there is no method whereby under a system of democratic government based on the federal principle the activities of federal governments in regard to the execution of policies which the federal legislature can lay down under any Concurrent List in the Federation Act can be controlled without inviting a breakdown of the Constitution. I am, therefore, for these reasons quite unable to agree to the proposal of my colleagues in this regard.

2. I now come to another recommendation to which I cannot agree. My colleagues urge that the Central Ministry of Health should be empowered to meet the obligations assumed by the Central Government under the provisions of international treaties. The present position in regard to the implementation of international treaties is to be found in section 106 of the Government of India Act which I reproduce below :—

- (1) The Federal Legislature shall not by reason only of the entry in the Federal Legislative List relating to the implementing of treaties and agreements with other countries have power to make any law for any province except with the previous consent of the Governor, or for a Federated State except with the previous consent of the ruler thereof.
- (2) So much of any law as is followed only by virtue of any such entry as aforesaid may be repealed by the Federal Legislature and may, on the treaty or agreement in question, cease to have effect, be repealed as respects the province or state by a law of that province or state.
- (3) Nothing in this section applies in relation to any law which the Federal Legislature has power to make for a province or, as the case may be, a Federated State, by virtue of any other entry in the Federal or the Concurrent Legislative List as well as by virtue of the said entry.

It will be seen that section 106 as explained by Mr. Butler in the House of Commons refers especially to items in the Federal Legislative List and gives the Federation power to legislate for the implementing of treaties and agreements with other countries under Item 3 of the Federal Legislative List. According to this section if the Federation is to legislate for the implementing of a convention of the type mentioned, it must secure the consent of the units concerned. Thus Mr. Butler emphasised in the debate on the Government of India Bill on the 27th March 1935 that the arrangement embodied in the Section is in accordance not only with commonsense but with the precedents and practice of all other Federations, and was envisaged by the framers of the Peace Treaty 'when they dealt with the question of Labour Conventions'. It is not clear to me exactly what my colleagues want. But if it is their intention that the law should be changed so as to give to the Central Legislature power to legislate and issue executive directions in regard to the implementation of those treaties which require the consent of the provincial units, then

I am bound to state that I differ from them. I think the wise course in implementing international treaties, agreements and conventions is to proceed, as Sir Samuel Hoare stated in the same debate, "not by coercion but by consent and to leave it to public opinion both in the provinces and the Indian States to mobilise itself behind the movement for better conditions." The reason why the framers of the Act of 1935 considered the consent of the provinces and the States essential is that the services covered by international agreements are often services which come within the activities of the units and it is essential that in these cases they should be prepared to carry out the agreements.

3. I have agreed to the appointment of a separate Minister of Health at the Centre for the following reasons:—

(a) Health is a subject of major importance for the country as a whole and a separate Ministry would tend to emphasize this.

(b) A separate Minister will have no divided loyalties and be free, without having to consider or coordinate the claims of other nation-building departments, to press the claims of health, particularly in the matter of grants on his colleagues.

(c) A separate Minister would be useful, in view of the political position that he will occupy, in devising methods of coordination and cooperation between the Centre and the provinces.

(d) A separate portfolio of Health would ensure political supervision over a Department some activities of which would remain under central control and other activities of which would require sympathetic understanding of the difficulties and points of view of the provinces.

(e) A separate political chief is essential, in my opinion, to control the activities of permanent officials and experts and establish liaison between the Department of Health and the public generally.

But while I agree that there should be a separate Minister of Health, I am not happy with the phraseology of Clause (1) of the paragraph in which the functions of the Central Ministry of Health have been set forth. Clause (1) reads as follows:—

"To study and plan schemes for health services, preventive and curative, for the whole of India; to revise or modify such schemes from time to time and to assist and co-ordinate activities for the expansion and improvement of health service in the provinces."

The words "study and plan" can be taken to suggest that it will be for the Ministry of Health to evolve plans and for the provinces to implement them irrespective of the fact whether they are in agreement with them or not. If my interpretation of the clause is correct, then my colleagues contemplate an extension of the functions of the Centre to an extent which would reduce in health matters the autonomy which the provinces enjoy at present. For this reason I would make it clear, in enumerating the functions, that the plans evolved by the Centre are only meant for the consideration of the provinces and that it will be open to them either to accept or reject them. I would accordingly modify the wording of this clause in this manner:

"To study and plan schemes for the consideration of the provinces of health services, preventive and curative, for the whole of India; to revise or modify such schemes from



time to time for their consideration and implementation and to assist and coordinate activities for the expansion and improvement of agreed programmes of health services in the province."

Similarly in Clause (6) which runs as follows:—

"To collect, tabulate and publish the vital statistics of the various component parts; to undertake a periodical census at such intervals as may be laid down by law to direct the organisation and the carrying out of statistical studies in any part of the country designed to throw light on any aspect of the health problem."

I would recommend for the latter part of the clause the substitution of the word "recommend" for the word "direct". The latter part would thus read: "To recommend the organisation and the carrying out of statistical studies in any part of the country designed to throw light on any aspect of the health problem." This would preserve statistics as a completely provincial subject and there would be no departure from the principle of the distribution of powers as laid down in the Act of 1935.

4. I have set forth, in a separate memorandum, my views on the reorganisation of Local Self-Government with particular reference to health activities. This is a question which the provincial Governments need to tackle in the interest of the future health administration of the country. For upon the efficiency of local bodies will depend in no small measure the speed with which the health programme will be implemented.

I may indicate that I am in general agreement with the principles which underlie the Madras Public Health Act, and I warmly welcome the adoption of its general principle by other governments. Local Self-Government has suffered in efficiency because of a number of other reasons (a) local bodies have not been supplied with adequate funds by the provincial Governments, (b) the method of electing and solving them and ordering fresh elections when things are not going well with them has not been resorted to, reliance having been placed upon the superseding powers of Government, (c) the chairman has not been independent of the board and (d) the services have not adequate security of tenure and no standardised emoluments. I have suggested in a separate note that (1) the chairman should be directly elected and have powers independent of the board, (2) that his position should correspond with that of a mayor, (3) that the executive administrative control technical supervision should be substituted, (4) that there should be a Local Self-Government Board to advise the Ministry of Local Self-Government in regard to all grants in aid to the local bodies, (5) and that the members should be recruited by the boards on the advice of Local Self-Government Public Service Commissions and (6) and that they should have the right of appeal to this body in cases of censure or dismissal.

But while these proposals provide a solution of the problem in areas where the intensive scheme for health development which we recommend is not operative, separate treatment of units where the experiment of health service is being tried on lines recommended by us is necessary in the interests of planning. For these reasons my colleagues suggest that district health boards—rural and urban—

should be appointed on which the local authorities can be given representation. Once elected, these health boards will be, more or less, independent of the local bodies in the district. The local bodies will be bound, however, to contribute a fixed proportion of their revenues to them. The difficulty that I foresee in this plan is that as District Health Boards, once they are constituted, will not be answerable to local bodies, the latter will have no direct incentive to improve their financial position by levying cesses to the extent that the capacity of the population in their areas can bear. I would, therefore, make the District Health Boards accountable to the local bodies by requiring that (a) they should keep them informed of their activities and the manner in which funds allotted to them are being used, the Local Bodies having the power of considering and passing resolutions on the annual report, the annual accounts and the policies adopted by the District Health Boards in the year. (b) by giving to local and municipal authorities power to make recommendations to them for the carrying out of the health programme or alterations in their bye-laws etc. and (c) by requiring that the term of office of the members of the District Health Boards a substantial majority of whom shall be members of Local Bodies, shall not exceed a maximum period of two years, it being open to them to be re-elected. It may be desirable in these areas to recruit on a provincial basis certain of the more important posts but it is my emphatic view that recruitment to the other comparatively minor posts should be left in the hands of District Health Boards and that for this purpose there should be available to them the advice of a Public Service Commission for Local Self-Government.

The size of the central secretariat on which my colleagues lay stress will depend, of course, I take it, upon the extent to which our proposals both in regard to the Centre and the provinces are to be implemented. I have no doubt that our recommendations are not intended to make the administration top heavy. I say this in order that there may be no misunderstanding as regards the reasons which have influenced me in agreeing to the remodelling of the secretariat on the lines suggested by us.

I should also like to say that, in my opinion, the question of the salaries to be paid to the members of the health services, both superior and inferior, is one which cannot be isolated from that of scales of pay generally agreed to by the country in regard to other professional, technical and even administrative services. It is my considered view that the present scales of pay are too high for a country with the national income of India. This question of salaries should be considered by a separate committee which can deal with this problem from a coordinated point of view.

I may also say that I would prefer the medical benefits under the Health Insurance Scheme, if any such scheme is eventually decided upon, to be administered by the Health Department until such time as this country comes to possess a proper Ministry of Social Security. My reason for this recommendation is that the problem of administering Health Insurance on a coordinated basis may be easier if Ministers both in the Centre and in the provinces are made responsible for both medical benefits and cash benefits. On this point I confess that the arguments are evenly balanced and it is, therefore, only in a tentative way that I make this suggestion. I

would suggest a separate departmental head for the administration of cash benefits. He will be under the control of the Ministry of Health. So will the head of the medical benefit section too be under the Health Minister. The two will be able to work in greater co-operation if they have to serve one head.

### **Minute on Local Self-Government by the Hon'ble Mr. P. N. Saprú**

#### **PART I**

A question to which my colleagues have devoted some attention is that of the relationship of health authorities at the provincial centre to Local Bodies. Shortly put, their view is that the interests of planning require the replacement of the existing local authority, or authorities, in demonstration areas by a new type of organisation capable of creating and maintaining uniform health services throughout the area or areas. In regard to the remaining parts of each province, their main recommendation is that measures on the lines taken in the Province of Madras by the Public Health Act of 1939 may be adopted for raising existing standards of health administration to a reasonable level of efficiency.

My point of view is somewhat different from that of my colleagues and I, therefore, consider it necessary to set it forth as briefly as I can. Hasty condemnation of Local Bodies, urban and rural, is easy but in passing a considered verdict on them, it must not be forgotten that their grants and resources are grossly inadequate and even with the best of will, they are not in a position to carry through big reforms. The general poverty of the country is reflected in their revenues and public health has, in the past, been looked upon as the *cinderella* of provincial departments. It is not claimed that the administration of Local Bodies is ideal; but it must be remembered that they have limited resources, that provincial Governments themselves have not helped them to the extent that they should have with financial assistance, that the only remedy which Provincial Governments have employed in improving the tone of incompetent Local Bodies is supersession and that they have done little to stimulate the growth of public opinion on Local Self-Government by resorting to dissolution for purposes of focussing attention on local mal-administration. It is proposed to confine this note to a few suggestions which would make Local Bodies more efficient and remove, without taking away any of the powers which they possess, some of the defects in their working. It is also proposed to consider some methods whereby even in the demonstration areas planning can be reconciled with the autonomy of a new type of local body suited to promote the creation and maintenance of a uniform health service throughout the area.

Control over Local Bodies is exercised, at all events, in the United Provinces with which I am most familiar, through Commissioners who have a good deal of revenue work. As an alternative to the present system, I advocate that control over Local Bodies should be vested in the Ministry of Local Self-Government who should be advised for this purpose by a Local Self-Government Board. The Chairman of the Board should be the Minister of Local Self-Government. Its Members should include (a) a certain number of

ministers, or their deputies, dealing with such portfolios as Education, Public Health, Labour, Social Security, Communications and Industries; (b) Elected representatives of Municipal and District Boards and the Chairmen of these boards; (c) Elected representatives of Medical and Engineering professions, and of Universities, Chambers of Commerce and Trade Unions as well as (d) a certain number of public men nominated by the Minister of Local Self-Government to represent interests or communities which have been unable to obtain representation through (b) and (c). The Board should be required to elect a Standing Committee, predominantly non-official in nature, which should be available to the Ministry for advice from time to time.

The primary functions of the Board will be (a) to evolve co-ordinated policies for Local Self-Government Bodies in regard to the functions entrusted to them; (b) to advise the Ministry on matters referred to it; (c) to pass resolutions of a recommendatory nature for the consideration of the Ministry and Local Bodies for promoting Local Self-Government; and (d) to advise the Ministry in regard to the distribution of provincial grants for the various purposes falling under the purview of Local authorities.

The conditions upon which grants are to be given should be specifically laid down and the amount of the grant should vary with the extent of co-operation shown by an individual Board with the policy laid down by the Provincial Ministry after consultation with the Local Self-Government Board or its Standing Committee. It should be open to the Ministry to give no grant to a Board where it finds that it has not been co-operating with the policy enunciated by it.

The various heads of departments would, under the scheme contemplated, be the principal administrative officers for supervising and inspecting the local authorities. The staff of these departments would need to be increased. Commissioners or their agents, the district officers, would cease to exercise control over Local Bodies. The Local Self-Government Board to be constituted under the scheme outlined by me, should have a Secretary whose status and emoluments should correspond with those of Secretaries in other departments of Government. The accounts of Local Bodies should be subject to audit by auditors appointed by Government. Local Bodies should be required to submit their requirements for grants to the Provincial Governments who would, in distributing them after taking into consideration the advice of the Local Government Board or its Standing Committee, bear the following principles in mind:—

(a) the willingness, as disclosed by the system of local rates, of a local body to levy taxation in proportion to the capacity of the various classes of rate payers;

(b) the schemes, and their practicability, which the Local Body in question has in mind;

(c) the efficiency of the services it provides;

(d) the treatment it metes out to its public servants;

(e) the zeal, if any, it has shown in promoting the welfare of the poorer sections of the population and

(f) the needs of the area under the Local Body and the order in which they should be taken up.

The Provincial Government should further keep a staff of experts in town planning, sanitary engineering, industrial health and labour welfare activities and such other activities as may be regarded useful. The advice of this staff should be available to Local authorities for schemes initiated by them.

Local Bodies should be subject to periodical inspection, on behalf of the Minister of Local Self-Government by administrative heads and by officers specially appointed for the purpose. Their reports should be available to the Local Self-Government Board when it is called upon to discharge its function of advising on grants. The reports should be published, where possible, and the Secretary should be responsible for an annual review of Local Self-Government administration. The Director of Public Health should have the powers in relation to health matters envisaged for him in the Madras Public Health Act of 1939.

The system outlined above would ensure (a) more regular as also expert inspection of boards (b) greater control over them by the provincial Government through a system of grants-in-aid and (c) popular plus expert control. The local self-government board would, it is claimed, make planning workable with popular control. It would not impair the responsibility of the Minister-in-Charge as it would be an advisory body of high status.

## PART II

One of the defects from which Municipal administration at the moment suffers is the position of the Chairman. In my opinion it is essential, for the smooth functioning of local administration to secure for the Chairmen of Local Bodies independence of tenure. The Chairman in a bigger Municipality, that is, in a town of over 80,000 population, should have the status of a mayor, should be called by that name and should have a high place in the warrant of precedence. In my opinion, the time has arrived when the mayors of presidency towns should be given the status of 'Lord Mayors' and have a place in the warrant of precedence equal to that of a member of the Upper House of the Central Legislature. I may mention that the Mayors of Sydney and Melbourne in Australia are called 'Right Honourable'. The Mayors and Chairmen should be elected directly by the people of the local area concerned. As they will be directly elected by the people, they will not be affected by any adverse vote of non-confidence. They should have the right, where a Board is obstructive, of advising Government to dissolve it and hold fresh elections. These suggestions have been made with the object of securing a good class of person for the Mayoralities and Chairmanships of the larger Municipalities.

Where there is a persistent conflict between a local authority and its Chairman, the Minister, on the advice of the Standing Committee of the Local-Self Government Board and in urgent cases without, should order fresh elections either—(a) of the Local Body or (b) of the Chairman, or (c) of both, as the case may be.

The servants of the Local Body should be answerable to the Chairman or the Mayor and take orders from him. The normal method of dealing with a Board, which is proving obstructive or inefficient, should be not supersession but a fresh general election. These reforms should help the formation of healthy civic opinion on matters

of importance and interest to the people of the town or area concerned.

Provincialisation of services at present controlled and recruited by local authorities will, I apprehend, be unpopular. In fact, I would have no provincialised services in the local bodies. Further, provincialisation is likely to lead to friction between these bodies and the public servants who have to work under them. The desire of the services for security of tenure is understandable, and it is true that insecurity leads to a lowering of standards and falling off in the quality of recruitment. But there are other ways of securing this end and, in my opinion, we should carry the maximum number of people with us in the reforms we suggest in local administration. The scheme which I suggest for the future recruitment of all Municipal and District Board services is as follows:—

(1) A Local Self-Government Public Service Commission should be constituted by an Act of the Provincial Legislature in each province.

(2) It should normally consist of a Chairman nominated by the Ministry of Local Self-Government and of two or more members appointed by the Minister of Local Self-Government. All matters relating to the health services under Local Bodies, including their recruitment, conditions of service and disciplinary control should be referred to this Commission and its advice should, normally, be followed by the Ministry of Local Self-Government. It should be open to the Commission to divide itself into sub-committees for the purposes of selection of officers.

(3) All appointments including those of sanitary inspectors should be made by local bodies on the recommendation of the Local Self-Government Public Service Commission. When the Commission or a sub-committee of it is making a recommendation for appointment to a particular local body, it should coopt a Member of that Board for the purposes of advising it. This coopted member will, for the purposes of that sub-committee, have equal rights with other members of the sub-committee.

(4) The Local Self-Government Public Service Commission, constituted as indicated above, should be required to send three names in order of preference. It should be open to the Local Body to select any one of the three names suggested by it.

(5) If a local authority is dissatisfied with the names selected, it should have the power to refer back the nominations to the Appointment Committee, but if the latter adheres to its previous view, the Local Body will have to select out of the panel suggested by the Appointment Committee.

(6) Where possible, the principle of competitive examinations should be preferred. Where competitive examinations have been instituted, appointments will go by merit as determined by the examination and interview results. The examination should include a *viva-voce* test.

(7) The appointing authority, under the scheme, will thus be the local authority. It will appoint and control the services subject to the reservations and qualifications stated above.

(8) The local authority should have the right of transferring, censuring, demoting and dismissing its servants in such manner as

may be prescribed by the Acts laying down the procedure for this purpose. It is contemplated that the procedure should provide for a Committee of Inquiry before action is taken, or emergency action taken by the Chairman, or Mayor, is confirmed.

(9) Officers affected by the order of a local body should have the right of appeal to the Local Self-Government Public Service Commission, whose decision on this point should be final.

(10) Two or more Local Bodies may, by mutual agreement, evolve a machinery for the transfer of officers serving in one authority to another and *vice-versa*. These mutual arrangements will enable officers of Boards to have experience of more than one Board. There is no reason why these mutual arrangements should not exist between bodies responsible for urban and rural areas.

(11) Scales of pay and conditions of service should be laid down by the Local Self-Government Board after consultation with the local authorities. The procedure for such consultation should be laid down in the Act.

(12) Clerical jobs may also be filled by the Local Self-Government Public Service Commission, if the Local Body so desires.

(13) Posts of Chaprasies, Jamadars, etc., may continue to be filled by the local bodies, but they should be statutorily required to have special Selection Committees for this purpose.

### PART III

In dealing with the question of the type of local authority needed for areas in which intensive work will be concentrated in the short period programme, my colleagues stress that it will be desirable to replace the existing local authority or authorities in these areas by a separate organization capable of creating and maintaining a uniform 'health service throughout the area'. They, therefore, recommend the establishment of District Health Boards on which local authorities in areas, rural as well as urban, can be given representation. The areas in which experimental work will be done include the province of Delhi, in the case of which my colleagues recommend that a Provincial Health Board should replace existing local authorities responsible for health administration in their respective areas. The change recommended by them in the system of local administration, so far as health is concerned, is thus of a far-reaching nature, likely to affect the whole basis upon which Local Self-Government is founded in this country. 'In the case of a city like Delhi, where a demonstration centre is intended to be created,' health activities administered by various Local Bodies will be merged into a province-wide authority. The reason for this suggested overhaul is that the separate functioning of one rural and two urban health authorities will militate against the development of an efficient and integrated health service. It is essential, so it is urged, to have an organisation which can exercise supervision and guidance over the growth of health administration in the peripheral units even as far back as the villages. The effect of these proposals will be to disintegrate Local Self-Governing institutions in the Delhi Province and other administrative areas where the short-term programme will be tried in an intensive form. I cannot help feeling that the proposals are not likely to meet with popular support. They would deprive Delhi City in particular of an opportunity to develop a first class

municipal corporation round which would help the growth of the civic life of the City.

The setting up of Provincial Health Boards in the case of Delhi Province and of District Health Boards in the case of other administrative areas would lead to the inevitable establishment of similar Boards for Communications, Education and Water-supplies. Such Boards would function, more or less, independently of any city or district organization which can view the problems of health, education, communications, water supply and housing in a connected or correlated manner. Men of position interested in civic life would have less incentive to offer themselves for elections to these boards as their status is certain to be less than that of municipal or district board which deal with all aspects of a city's life. It is, in my opinion, therefore, essential that in the name of planning, which admittedly necessitates some centralization, an experiment should not be tried which would strike at the very foundations of Local Self-Government. Assuming that it is desirable to merge Local Bodies into a province-wide authority as in the case of Delhi, or a district authority as in the case of other demonstration areas, it is essential to secure that the local authority so set up shall, while empowered to split itself up into separate committees or boards for the more convenient transaction of business, have the ultimate control over the activities of Boards or Committees dealing with the special subjects with which they are charged. Confining myself to the Delhi Province for the moment, I would create an autonomous corporation with a Chairman elected directly by the people dealing with all activities for which either Municipal or District Boards in the province are responsible. This province-wide Board shall be the supreme governing body for the area concerned and shall have the power to review the acts of the Committees set up by it. It may delegate such of its functions as it chooses to Standing Health Committees or other similar bodies but it and it alone shall, on their recommendation, make bye-laws, consider and cancel them, levy local taxation, consider and pass resolutions on the Annual Report, the Annual Accounts and the financial estimates, which shall be submitted to it for approval by its Chairman. In other words, the power of passing the Budget and sanctioning expenditure in accordance with certain principles laid down in the Act constituting the Corporation shall reside exclusively in the Corporation, save and except in so far as it may have delegated certain powers to a Committee or Board elected by and responsible to it.

Under the proposal adumbrated above, urban and rural authorities have been merged into one. This has been done to ensure co-ordination. This new type of Council shall, however, continue to be elected by territorial constituencies plus where necessary some special representation for certain interests such as the medical profession. Standing Committees or Boards constituted by the Local Self-Governing authority shall be definitely subordinate to it. They shall have no power independent of the District Council which is the name by which I suggest this type of Local Self-Governing authority should be known. I may state that I am in favour of the Act prescribing the constitution of the Provincial Council in the Delhi Province and the District Council in other provinces laying down that the Health Department shall exercise, broadly speaking, the amount of control which the Health Department in Madras possesses



over local authorities under the Public Health Act of 1939. Regarding the mode of appointment of Health Officers and other health staff, including sanitary inspectors, my preference is for a scheme which lays down minimum standards in the matter of qualifications, etc., but which leaves actual selection to the District Councils concerned from a panel suggested by an Appointments Board or Boards on which a Local Self-Government Public Service Commission to be created in accordance with my recommendations on local-self government and the Council itself are both represented. Officers so appointed should be directly responsible to the Chairman for day-to-day administration. The power of the boards to censure, suspend or dismiss their officers should be subject to appeal to, and review by, the Local Self-Government Public Service Commission, whose decision should be final. It is claimed for this scheme that while it does not impinge upon the autonomy of Local Bodies, it at the same time ensures fair treatment for the officers serving under them. Further merits of the scheme which I have put forward are that (a) it ensures that local cesses shall be levied by a body competent to take all the needs of a city or District into consideration; (b) it does not diminish the measure of self-government enjoyed by Local Bodies at the present moment; (c) it makes for their smooth working, by giving to them a Chairman directly elected by the people and possessed of sufficient authority to make his impression felt upon the administration of the city, as a whole, and (d) it makes no breaches in the essential principles upon which these Bodies have been functioning for almost two generations. What it proposes to do is to adapt the existing system of separate Local Bodies for urban and rural areas by one central District Council so that it may effectively carry out the health programme outlined by the Committee. The Chairman of the Provincial Council in the case of Delhi Province and District Councils in other demonstration areas shall, of course, be elected directly by the people.

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## CHAPTER XVIII

### PROFESSIONAL EDUCATION

#### Introduction

1. Our specific recommendations for the future in connection with professional education are designedly limited in their scope. They only aim at a detailed depiction of the development we suggest as a short-term policy covering a space of 10 years. In dealing with the period beyond this initial stage, it would be unwise to indulge in any detail or to do more than indicate in the broadest outline the general lines of further advance. If the foundation is well and truly laid during the first 10 years on the lines suggested by us, we feel that subsequent progress will be possible at a greatly accelerated pace. Modifications, which experience or altered circumstances may dictate, can be made without any serious retracing of the initial steps. Our main objective during this period must be the provision of adequate staff suitably trained to enable the plan of health work which we envisage to be developed as early as circumstances permit. Progress towards our eventual goal depends on the fulfilment of this requirement and it must therefore be conceded the highest priority in our programme. We shall deal with professional education under the following two heads:

A. Certain general questions germane to the subject of professional education which call for preliminary notice and

B. Our specific proposals in respect of education for the following types of health personnel:

- (1) Medical Education;
- (2) training in Dentistry;
- (3) training in Pharmacology;
- (4) training of certain types of Public Health Personnel;
- (5) training of Nurses and Midwives;
- (6) training of Hospital Social Workers, and,
- (7) training of Technicians.

#### A. CERTAIN GENERAL QUESTIONS FOR PRELIMINARY CONSIDERATIONS

##### (1) Doctors

##### (a) The Target in regard to the Number of Personnel

2. It has been pointed out that there are approximately 47,400 doctors available in the whole of British India. The inference, however, cannot be drawn from this figure that taking the total population into account, one doctor is available for about 6,400 of the population. We are faced with the obvious fact that large numbers of doctors congregate in the cities and larger towns, while great tracts of the countryside are left unserved by any medical men qualified in the scientific system of medicine. There are undoubtedly a certain number of persons practising the indigenous system in these rural areas with varying degrees of efficiency. But confining ourselves to the system with which alone we propose to

deal in this report, we can say quite definitely that the proportion of doctors to the rural population is generally such as to result in an almost total denial of effective medical aid to the people. We have calculated that the fulfilment of our long term policy will demand something like 250,000 doctors. We are, however, here concerned only with the next 10 years and at the end of this period, we consider that the 47,400 doctors available today will, if our proposals are carried out, be increased by about 22,000 while the number required for the implementation of the short-term programme is about 29,300. This increase will of course be subject to the wastage during this period. Even so, the number of doctors available for public service will be well in excess of the number required for our scheme during the short-term. The problem is, however, essentially one of distributing them over the rural areas where they are at present few in numbers. Their proper distribution to meet the requirements of the general population of this country can, we believe, only be ensured through a paid Government service which will secure the effective provision of doctors where they are most needed. This we have already pointed out.

3. If our recommendations are accepted and given effect to immediately, then at the end of the first ten years, the medical teaching institutions in the country should be capable of an annual output of 4,000 to 4,500 doctors as compared with less than half that number of graduates and licentiates combined produced each year at present. This may not be considered a very striking advance. Nevertheless, it is substantial and the early years must necessarily be a period of limited growth during which initial impediments, which we will refer to later, have to be overcome and the conditions for more rapid progress created. We feel confident, however, that at the end of the first 10 years, it will become possible to increase considerably the momentum of the advance if the driving force behind it is not allowed to flag.

#### (b) Factors impeding speedy expansion of Medical Education

4. In any scheme for the expansion of medical education, the most important consideration is the provision of teaching staff possessing proper qualifications and the necessary aptitude for the work. War conditions have rendered it impossible or at least extremely difficult for members of the medical profession in India to visit foreign countries within the last six years to acquire such additional qualifications as would make them suitable for appointment as teachers in medical colleges. This would not have been a serious handicap if the authorities concerned had realised adequately their responsibility for the development of post-graduate medical education. No steps worth mentioning have been taken, however, to create a proper postgraduate council of medical education at any of the large teaching centres and both the Universities and the Government must share the responsibility for this failure. The problem of providing an adequate number of qualified teachers for the medical colleges, visualised in our proposals, is a serious one. There are, however, ways in which it should be possible to overcome or at least reduce the difficulties which confront us.

5. We have referred elsewhere to the All-India Medical Institute which, if it is brought into existence, will not only provide a centre for the training of medical teachers but will combine the provision

of the most up-to-date hospital facilities for the education of medical graduates and opportunities for comprehensive research without which teaching and training must fail in their object. When this centre is fully developed, it will, we hope, provide a steady, if limited, stream of teaching personnel of the highest quality for the various medical colleges in the country. But before this restricted source of supply can be drawn upon, some considerable time must elapse and in the meantime the Medical Colleges cannot wait with closed doors for the teachers they need.

6. It may be possible to obtain a few from outside the country on short-term contracts, but it is extremely doubtful if this is likely to prove a fruitful source of supply. The conditions created by the war have seriously depleted the teaching personnel of medical colleges in Great Britain and the same is probably true of the United States of America. It would appear that the demand for both full-time and part-time teachers in medical colleges in the United Kingdom will be stepped up and as the Goodenough Committee has itself envisaged, there may not be enough to meet even British requirements for sometime to come.

7. We do not consider it desirable to recruit persons merely because of their academic attainments if they do not possess teaching experience and the general qualifications necessary for the higher grades of professional staff, *i.e.*, research work, specialist qualifications and teaching ability. If, however, it is possible under present conditions to obtain the services of such men from abroad, they should be recruited on short-term contracts to fill a gap which we must ensure is only temporary. It should be the definite endeavour of the State to provide all facilities for selected medical men trained in India to acquire such qualifications as are necessary to enable them to supply the bulk of the ordinary teaching staff of the medical institutions in this country. For this purpose, we would suggest that suitable persons with good qualifications should be sent abroad for periods ranging from 6 months to 2 years to some of the leading medical schools in Great Britain or America to equip themselves especially to fill teaching posts. It should be possible to find people of the requisite calibre and qualifications in the country today and in attempting to do so, regard should be had to the Indian officers serving at present in the Army who must by now have accumulated a rich store of experience in many branches of medicine. It seems desirable that, if such persons are selected, they should have early priorities guaranteed them when the question of demobilisation is taken up to enable them to undergo abroad short courses of training as teachers. We are of opinion that, as soon as possible, an endeavour should be made to send about 200 selected members of the medical profession in India from the various provinces to countries abroad to acquire a knowledge of the methods of teaching and up-to-date experience in their respective subjects on condition that they bind themselves on return to serve in the medical teaching institutions of the country. In particular, we would welcome such arrangements being made in the following branches of study, Anatomy, Physiology, Bio-chemistry, Pathology, Bacteriology and Pharmacology.

8. The facilities for postgraduate training and for research work in foreign universities, which can be made available to our medical

graduates in the coming years, will naturally be limited. It is therefore essential that, in the interests of the country, such opportunities should be made use of to the fullest possible extent. The Central and Provincial Governments will naturally employ the official representatives of the former in London and Washington for the proper 'placing' of their own scholars. It is desirable that those medical men who seek, independently of financial help from Government funds, similar opportunities for advanced training in those countries should have clear ideas as to the courses of study they desire to pursue and the institution in which they desire to prosecute them, and should have secured guarantees of admission to the latter before leaving India. We feel that in this way the limited facilities available for training abroad will be utilised to the best advantage of India. We have been informed that, in the past, many graduates from this country used to arrive in Great Britain with no definite plan of work and drift from one institution to another collecting a mass of diffuse knowledge, with little practical relation to their future activities in India. Our proposal is intended to minimise the occurrence of such cases.

9. We hold the view that, ordinarily, no one should be appointed head of a department of study in any branch of medicine who does not possess a high post-graduate qualification, some recognized research work to his credit and has not also had opportunities of visiting foreign Universities for a minimum period of six months.

10. In this connection, we would invite the attention of those concerned to the desirability of laying down carefully considered minimum qualifications for the various grades of teachers. Such minimum standards obtain in some of the Indian Universities and it should be the rule that no one should be appointed as a teacher who does not fulfil these minimum requirements.

11. As a general policy we would suggest that the younger men should be encouraged in increasing numbers to acquire post-graduate qualifications in this country and that it should be made possible for the best of these, at a later stage, to round off their medical education by visits to foreign countries for periods of from 6 months to one year.

#### (c) **The Type of Doctor for the Future**

12. We have given serious consideration to a suggestion that in the conditions now prevailing in the country, there is room both for the fully trained doctor and a less elaborately trained type of medical man whose main recommendation would be that he could be produced in larger numbers.

13. The great lack of doctors leaves the bulk of the population of the country without medical service of any sort and it is contended that the insistent need, therefore, is to increase the supply of medical men. In these circumstances, it is argued that a less elaborately trained doctor is better than no doctor at all and that such a doctor, though he may not be able to supply the same service as a more fully trained medical practitioner, can still make a valuable contribution to the health of the community in general and supply some measure of medical help to the individual who, but for his aid, would be entirely without medical attention at the hands of exponents of the system of modern scientific medicine.

14. The "Feldsher" type of doctor has proved a valuable part of the medical organisation in Russia and there appears to be no reason why he should not fulfil an equally effective purpose in this country. This is obviously a point of view which demands most careful consideration. It cannot be ignored or overridden by an *ex cathedra* pronouncement.

15. We have given considerable thought to the question and the conclusion which the very large majority of our members has arrived at is that, on the whole, having regard to the limited resources available for the training of doctors, it would be to the greater ultimate benefit of the country if those resources were concentrated on the production of only one and that the most highly trained type of doctor, which we have termed the "basic" doctor. We have made detailed recommendations, later in this chapter, regarding his training.

16. The following are some of the considerations which have influenced this conclusion:—

(a) No one, it is believed, would suggest that the expedient of having a corps of less completely trained medical men should be resorted to if fully trained doctors were available in requisite numbers. It must, therefore, be assumed that such an expedient is proposed as a temporary device and not as a permanent feature of the medical organisation of the country. Its value, even as an interim expedient, is open to varying assessments.

Clearly, if the argument of numbers is the decisive consideration, then its validity must vary inversely with the standard of the training given. The lesser the training and hence the more rapid the production of such a doctor, the stronger would of course be the argument in support of such a plan. Whatever may be the intentions of the exponents of the view that there should be two grades of doctors, there will always be the temptation to increase numbers by lowering the standard of training. Such a tendency might well lead to deplorable consequences. On the other hand, if the shorter training is to extend to four years or slightly less as compared with the 5 years for the "basic" doctor we contemplate, the advantage to be derived from larger numbers may be so attenuated as to be hardly worth achieving.

(b) Our "basic" doctor's training includes, as an inseparable component, education in the community and preventive aspects of medicine. A hastily manufactured doctor is not likely to be able to find time for effective training in these departments of health activity which we all consider of vital importance. It is open to question whether the ultimate benefit to the wider and more fundamental interests of the community derived from a smaller number of better trained doctors, adequately fitted to fulfil the comprehensive role we are laying down for them, will not be greater than that resulting from a larger number of doctors who, by their inadequate training, would be unfitted or at least far less fitted for the wider duties which the doctor of the future must be capable of discharging.

(c) With the limited training facilities at our disposal, which are not susceptible of immediate expansion on any very substantial scale, the diversion of a medical educational institution from the task of producing fully trained doctors to one of producing a type

of personnel with inferior training is to be deprecated, for it must inevitably postpone fulfilment of the ultimate aim which **may** be defined as a complete health service for the community at the **hands** of a fully trained and competent staff.

(d) A doctor with the 'basic' training proposed by us, supported by adequate and efficient technicians and other ancillary personnel, is capable of extending his sphere of public utility to an extent which would be quite beyond the capacity of an imperfectly trained doctor and this fact may largely discount the argument of numbers, on which the advocates of the view that any kind of doctor is better than none rely. We therefore consider that the limited funds likely to be available will be much more advantageously utilised in training larger numbers of essential ancillary personnel, without whom a doctor's sphere of utility must be strictly circumscribed, than on merely producing larger numbers of a less effective type of medical man than the 'basic' doctor.

(e) An imperfectly trained doctor is likely to forget his limitations and to attempt medical ministrations beyond his capacity to the possible detriment of the public.

(f) The production of two types or grades of doctors is to be deprecated on general grounds. The doctor with a lower status tends to develop an inferiority complex and a chronic discontent which cannot but be inimical to good work.

(g) We have had overwhelming evidence in favour of having only one grade of doctor—the highest.

(h) The licentiate class has done yeomen service to the country but the Associations of Licentiates have been unanimous in the view that this class of doctor should not be perpetuated.

(i) The acceptance of this view by two Provincial Governments when Congress Ministries were in power and the movement towards it by others seems to indicate that there is a powerful volume of practical administrative experience against the alternative which has been fully tried out.

(j) This view, which we have accepted, is not based on purely personal grounds. It takes into account the effect referred to above, which cannot but be reflected in a doctor's work if he is dissatisfied with the conditions under which he has to carry on his professional duties, with the status of comparative inferiority which he must inevitably occupy as compared with the medical graduate, and if he is constantly labouring under a real or fancied sense of grievance.

17. While, therefore, we feel that the dissenting view held by six of us merits every consideration, the rest of us are of the opinion that the balance of advantage lies indubitably with the conclusion that taking the longer view, it is in the best interests of the community that the available facilities should be concentrated on the production of one type of doctor with the basic education we are recommending. We attach the minute of dissent on this question signed by those of our colleagues who do not agree with the view of the majority. We venture to think that there is really no fundamental disagreement between the views of the majority and those of the dissenting members. The majority contemplate that it will

be ten years before the training of licentiates can be completely discontinued, while the minority, who also agree that such discontinuance is desirable, merely suggest that a longer period should elapse before the licentiate class ceases to be produced.

Two other notes on this subject are also appended at the end of this section.

**(d) Portal of Entry into the Medical Profession**

18. At present the portal of entry to the medical profession is either through the University or through Examining Boards which control medical education. We have just recorded the conclusion that there should be only one type of doctor for the future and that he should receive the highest type of training. We consider therefore that there should, hereafter, be a single portal of entry to the medical profession and that portal should be the Universities. We are confirmed in this view by the reasons advanced by the Inter-Departmental Committee on Medical Education in Great Britain in support of university medical education. This is what the Committee has to say on this subject:—

“We recommend that in future only medical schools that are integral parts of Universities should undertake the training of undergraduate medical students. To agree to the training of medical students in institutions which are not parts of Universities, is to support the belief that doctors can be produced in intellectual circumstances that are not the best that the community provides. We cannot accept such a belief. Medicine is a branch of human thought and activity that demands and provides opportunities for the fullest development of humanistic and scientific talents. It is a branch of higher learning and the most favourable training ground for those who follow it is in the recognised centres of higher learning—the Universities. We are certain that it is as full participants in the life of Universities, having close associations with those following other branches of learning, that teachers of medical students will receive the strongest stimulus to give of their best, and medical students will be encouraged to develop those qualities of mind and character that make a good doctor. A University Medical School presents the most favourable conditions for maintaining and improving educational standards; for securing a consistent selection of good students; for attracting teachers of the highest calibre to the responsibilities of medical education, and for keeping alive their enthusiasm. It provides the best means for effecting essential contacts between teachers of Medicine and persons working in other spheres of learning, particularly the natural and social sciences; for ensuring the provision of accommodation and equipment of a standard and on a scale that is required; and for diffusing beneficial educational influences throughout the health and hospital services.

We strongly commend this view and suggest that the only channel in India for the grant of medical qualifications should be the



Universities. They are chartered bodies which will act in conformity with the standards laid down from time to time by the All-India Medical Council and which will be in a position effectively to control the pre-medical and medical standards of education required for the type of doctor which the country needs.

(e) **Co-education**

19. Co-education in Medical Colleges is a subject on which we think it necessary to express our definite views. Except the Lady Hardinge Medical College for women at Delhi and the Vellore Missionary College, which we understand will shortly be made a co-education centre, all other colleges in the country admit both men and women. In some of the latter, the proportion of women to men is 1 to 2, while in others only a very few women, half a dozen or at the most 10, have so far been admitted each year. We must ask ourselves the question whether, in a profession like medicine, it is not desirable to have co-educational institutions and whether it is really in the interests of the future woman doctor that she should be trained in a purely women's medical college. At the Lady Hardinge Medical College, women students receive all their training in a hospital exclusively for women except for a short 3 months' course at the Irwin Hospital where the Superintendent gives clinical demonstrations in men's wards. There are two aspects to this question. A complete course of training for women in any medical college is more likely to be ensured if the hospital to which it is attached has beds for men as well as women, for, in the opinion of many, there are diseases which can be studied more effectively in men than in women. The Woman's College, therefore, which is without a proportion of beds for men, cannot function with the same efficiency as a college where hospital facilities are provided for patients of both sexes.

20. The second consideration is perhaps even more important. Women doctors, in the exercise of their profession, cannot confine themselves rigidly to contacts with their own sex. When their work takes them into the homes of their patients, contact with the male members of the household may often be inevitable and indeed sometimes necessary in the interests of their patients. Moreover, with the larger emphasis that will hereafter be placed on social medicine, the woman doctor of the future must of necessity know how to move with men and women alike, of all classes and conditions, must cultivate tact and *savoir faire* and be able to hold her own in difficult circumstances in which she may often find herself. A co-educational institution is, in our opinion, the best training ground and preparation for the work that lies before a woman doctor.

21. It seems, therefore, highly desirable that the policy in future should be to encourage co-educational institutions. But conditions being what they are and the demand for women doctors being great, the need for women medical colleges will remain for some time. In any case, the provision within the same campus of beds for men, medical, surgical and perhaps some of the specialities with a proper out-patient department if necessary, seems advisable so that students may have access to male as well as female patients for purposes of study and observation. We recognise,

however, that there are other considerations which will have to be given due weight in coming to a decision in this matter.

(f) **Entry into Medical Colleges**

(i) *Women.*—22. The need for women doctors in this country cannot be over-emphasised. Except in the Province of Madras, however, women receive no special encouragement to take to the profession of medicine. Nor do the provinces have any definite rule as to the number of women to be admitted into medical colleges. In Madras women are exempted from the payment of fees at the three State Medical Institutions and 1/3rd of their admissions are reserved for women. The result of the large number of women students being trained in these colleges has been that they have provided the recruiting ground for women medical personnel for various States and many Provinces outside Madras. We feel that having regard to the great need for women doctors particularly in Northern India, all colleges should reserve a proportion of admissions every year for women if there are suitable applicants. We realise that there is greater wastage in the case of women than in the case of men. Women students sometimes leave in the midst of their studies to marry and settle down in life, while others after qualifying, for domestic or other reasons, tend to drop out of the profession more frequently than men. While taking all these factors into consideration, we still think that it will be in the national interest if from a quarter to a third of admissions to the large proportion of medical colleges were reserved for suitably qualified women candidates. In certain cases, it may be found advisable even to increase this percentage of reservation. We would, however, lay emphasis on the cardinal principle which should apply to all entry into medical colleges and which we set out below—the principle of merit tempered, where necessary, to provide for communal representation.

(ii) *Men.*—23. The fact which faces us most prominently today is the disproportionately large number of applicants for admission compared to the number that can possibly be admitted. It is not, therefore, strange that the methods of admission should be of special interest and should have come in for considerable criticism. We have been informed that, in many cases, admission is influenced by considerations which have no connection whatever with the merits of the candidates. We need not expatiate upon the evidence that has been given to us in this connection. We would only point out that the capacity of the medical teaching institutions in the country will continue to be limited for a considerable time to come, even after our recommendations are accepted. With the number of applicants for entry larger than the number of vacancies available, admission must inevitably assume a competitive character. It, therefore, appears essential to us that, as far as possible, the applicants best qualified to make use of the opportunities provided and most likely to fulfil the requirements of the doctor we need, should alone be taken into the colleges. In other words, merit should, so far as possible, be the test for admission. We realise that there are factors which militate against the application of this principle in its entirety. Communal considerations cannot be ignored in the present state of the country much as we may deplore the intrusion of this principle into the field with which we are dealing. We are, however, united in the suggestions we put forward in regard to the method of making admissions to medical training institutions in the

country. We understand that the competitive or selective principle is likely to be adopted in the United Kingdom if the Goodenough Committee's proposals are accepted and we have had it on the authority of Dr. Ognev, the Soviet Representative, that selection based purely on merit, regulates entry into the medical training institutions in the Soviet Union. We feel that a satisfactory compromise between this principle and the general feeling that minorities should be given a fair chance of entry into the profession would be achieved if a plan on the following lines were adopted.

24. A percentage of admissions to every medical training institution should be by pure merit alone, whatever the test that might be adopted. This proportion may be about one-third of the total vacancies. The rest of the vacancies may be divided among the communities and in the number selected on such communal basis no account be taken of those who secure admission on the basis of pure merit. For instance, if 80 per cent. of entrants from the open examination or admission test belong to a particular minority community, that minority community should not be denied its proper proportion of the remaining vacancies. The same applies of course to a majority community. It is however essential that even in the case of the minority communities, the communal proportion should be subjected to the test of merit and the best qualified from among a particular community's candidates should be selected for admission. Favour or influence should play no part in securing entry for a candidate.

25. We do not feel justified in formulating details of the admission test. This may well be left to the Universities. We should, however, say that any test which does not provide for assessing a candidate's personality, initiative, powers of observation and independent thinking will have largely failed in its object. A candidate's academic record should be given due weight, but character, physical fitness and athletic attainments should not be left out of account.

#### **(g) The Cost of Medical Education**

26. There is no doubt that the long course through which a student must pass before he is equipped to practise as a doctor, imposes a heavy financial burden upon those responsible for his education and in many cases the result may be to shut out the prospect of a medical career for those of limited means however suitable they may otherwise be. We feel that, apart from the injustice this involves for the individual, it is not in the interests of the State that economic barriers alone should prevent those otherwise well equipped to do so from taking part in work of such value to the community. This aspect of the question is now impressing itself more and more upon those responsible for medical training in other countries and the trammels of the past are being cast aside in favour of more rational thought and action. In Russia, medical education is free and, in the United Kingdom, the Goodenough Committee has recommended that one-third of the admissions to medical educational institutions should be free. We realise that even partially free medical education must impose a heavy financial burden on the revenues of the State, but in view of the necessity for increasing the number of doctors in the country and for ensuring the maintenance of their quality, we feel that it would be unwise in the interests of the nation not to face the

heavy bill that may be involved. We have recommended that admission to medical colleges should be regulated by a test with a view to the selection generally of the best qualified among those competing for entry, and we feel that it should be possible to evolve a system of providing the means of paying for their education, fair to the individual, advantageous to the community and not too burdensome to the State. We take into account the fact that if our recommendations are accepted, the demand for doctors for the next quarter of a century at least will be so heavy that if the State Medical Services, which we have visualised, materialise, it will be possible to absorb the entire output of the medical colleges for State service in this field. Bearing this consideration in mind, we suggest that all student entrants into medical teaching institutions should be given the guarantee that, if they complete their course satisfactorily and are otherwise suitable, they will be assured a place in the public service with specifically defined prospects. Those who do not wish to avail themselves of this offer, should be left to bear their own expenses. Those, on the other hand, whether men or women, who are prepared to enter the service of the State on the satisfactory completion of their course of medical training on such terms and conditions as may be laid down, should be given a sufficient allowance to cover not only the cost of their medical education but also their maintenance as well. An annual provision of Rs. 1,000 per student should be sufficient for this purpose. Assuming the course of study to extend over 5 years, it will mean that each student will cost the country Rs. 5,000. It is suggested, however, that this should not be an outright grant. Half, or if this is considered too little, two-thirds of this amount should be recovered from the recipient over a period of 10 years in easy instalments, the balance being written off. The loan would be free of interest and the individual would have to enter into a bond to serve the Government for at least 10 years. Failure to carry out this condition of service satisfactorily would entail recovery of the entire amount advanced to the student. We feel that, in this way, the door should be opened wide to all those who have the ability and are willing to serve the State and themselves by entering a profession which is so essential for the welfare of the nation.

27. We realise, however, the great obstacle which lack of funds is likely to interpose in the way of this recommendation being carried out. While we should like to see the subsidy paid to all entrants because of the difficulty of applying a means test, financial considerations may make this an impractical proposition to begin with. We have, therefore, made provision in our estimates for the payment of the subsidy to only about 50 per cent. of the entrants. These would have to be chosen from those least capable of paying their own expenses.

A certain proportion of bad debts will be inevitable, but this is a small price to pay for the object we are endeavouring to achieve.

#### (h) **Salaries of Teachers and Tenure of Appointment**

28. To secure the right type of persons, it is of course essential that adequate salaries should be paid. As we have explained elsewhere, we are not in a position to indicate with any assurance what the scales of pay should be, but have taken certain tentative figures as the basis of our financial estimates which may call for modification

in the light of the comprehensive investigation into the general question of salaries, which we are suggesting. We would also emphasize that full-time heads of departments should be appointed to every department of study, clinical and pre-clinical and that conditions of service should be such that there are reasonable facilities for research, for periodic visits to different training centres in India and abroad, and for opportunities of post-graduate teaching as well. Should our suggestion to send 200 doctors abroad with the least possible delay be accepted, we feel that within the next two or three years, a sufficient number of trained personnel will be available to supply the staff for many of the medical colleges we envisage for the country and if the system be continued, of sending abroad a certain number of Indian doctors every year till such time as the medical colleges in India are in a position to afford all the necessary facilities, there should be no difficulty in recruiting a suitable type of teacher for the medical colleges contemplated in our short-term proposals.

**(i) Medical Research in relation to Medical Education**

29. The organisation of medical research for India will be dealt with separately but the relevant question here is how far the medical colleges should interest themselves in medical research and what place medical research should find in a teaching institution. Every college of medicine should perform the three-fold duties of (a) training under-graduates, (b) training post-graduates in certain spheres of medicine, and (c) encouraging and fostering medical research in the teaching centres. We consider the last as one of its most important functions as without research in a medical teaching centre, the quickening atmosphere needed for encouraging original thinking in students and teachers, for instilling into them the need for the cultivation of the habit of enquiry and proper deduction and for stimulating observation would be lacking. It is unfortunate that, at present, medical research plays a very subordinate part in most of the medical colleges in this country. This is, however, not altogether the fault of these institutions. There has not been adequate encouragement nor have facilities for research been always sufficient, while paucity of staff has thrown much routine work on the teachers, leaving them little time or energy to devote to the task of research. At the same time, it must be confessed that research could have been done in a much larger measure if a greater amount of interest and initiative had been developed in the different medical colleges. We feel that medical research in teaching centres is so important that every encouragement should be given to this side of its activities and we recommend that the following measures should be taken for this purpose:—

(1) There should be at least one full-time member of the staff in charge of medical research who will be able to co-ordinate the different forms of medical research that may be done at a teaching centre and give advice and help where necessary.

(2) A number of young medical graduates, showing a special aptitude for this type of work, should be given scholarships for periods ranging from 3 to 5 years to pursue medical research at these institutions.

(3) Those who show special aptitude for and interest in research, should have an opening for continuing research as a life work.

(4) The different departments should have, at their head, full time Professors who have research achievements to their credit and these Heads should not be over-burdened with routine work.

(5) There should be periodic Group Conferences of the teaching staff of each institution including Surgeons and Physicians, Obstetricians and Specialists and the staffs of the departments of Pathology, Bacteriology, Pharmacology and Biochemistry. There should also be, in each medical college, a Board to stimulate medical research and to lay down and co-ordinate programmes and policies in regard to it.

(6) The special equipment and facilities needed for carrying on medical research should be supplied to all teaching centres.

(7) Funds for the purpose of research must be made available through a central agency.

**(j) Size of Medical Colleges and of the Hospitals connected with them**

30. It is ordinarily an uneconomical proposition for any college to have less than 50 students, while 100 should be considered the optimum number for admission. If our recommendations are accepted in regard to both the new colleges and the improvement of existing institutions to bring them up to the level we contemplate, it should be possible for these colleges to open their doors to a far wider number than are being admitted today. We have suggested that the optimum number should be 100. This, at the rate of 10 beds to one student would postulate a 1,000 bed hospital, which we recommend should be aimed at in connection with all medical colleges suggested by us. But we also recognise the dire need for increasing, at the outset, the number of doctors. We have also to take into account a certain amount of wastage and we would, therefore, suggest that during the initial stage, which may possibly extend for many years, the intake should be not 100 but if possible 120. When the position has eventually been stabilised in regard to the number of medical men required, then admissions may drop to the optimum considered advisable to secure the greatest attention to the needs of the medical student.

31. In referring to the hospital required to furnish the basis for a teaching centre, we would emphasize two important considerations which should be borne in mind. A teaching centre including a college and the connected hospital should preferably be in the same campus, so that a student may not be forced to waste time and energy in running from hospital to hospital and from hospital to college for the different specialities. A large general hospital with practically all the specialities in the different wings in the same campus and with a bed strength roughly of 900 to 1,000 beds is the ideal to be approached. Except for the two specialities of infectious and mental disease, the hospital should be self-sufficient in all other respects and should be in very close proximity to the college proper.

**(2) Nurses**

32. The need for nurses is even greater than that for doctors. There are no more than about 7,000 nurses at present and for the implementation of our scheme, we shall need 80,400 by the end of our ten-year programme, including public health nurses for outdoor duties. Here also in our opinion, a State service holding out reasonable pros-

pects of a life's career is the only means of assuring the availability of trained personnel of this category where it is needed. We must emphasize that our whole plan may be gravely jeopardised or at least seriously handicapped if it is unable to command the nurses which it requires.

33. We feel that it is even more essential, in the case of nurses, to provide conditions which will attract women of the right type for this honourable profession, which occupies a position of such crucial importance in our scheme of preventive and curative health organisation. We shall discuss this matter in greater detail later in this chapter.

34. A provision at the rate of at least Rs. 60 a month, to help to cover the cost of maintenance and training, should be made available for all suitable candidates. This will entail a total cost of Rs. 2,160 for the three years course of training in the case of each individual and we suggest that half of this should be treated as a loan and should eventually be recovered on the same general conditions as we have recommended in the case of doctors. We do not, however, conceal from ourselves the difficulties which, despite such assistance, will confront recruitment of adequate numbers to this branch of service, at any rate in the earlier years.

35. What we have said in regard to State service and under-training subsidies applies generally to the ephemeral class of the health visitor who will in time, we hope, be substituted by the public health nurse and also to the midwife.

## MINUTES OF DISSENT

### I

We are unable to support the conclusion of our colleagues that it would be to the greater ultimate benefit of the country if the limited resources available for the training of doctors were concentrated on the production of the most highly trained type.

Our survey has revealed a grave shortage of trained medical personnel of all types and we are deeply impressed by the necessity for making a supreme effort to increase their numbers to the maximum extent in the minimum time.

We agree with our colleagues as to the advantage of having one single type of doctor with a basic five years training in the curative and preventive aspects of medicine; but in view of the over-all shortage of doctors we feel that the early realisation of this ideal must be sacrificed to the immediate needs of the country. We are aware that the organisations representing the licentiate doctors have recommended the abolition of this class, but would point out that the reasons for this recommendation are certain grievances relating to professional status and treatment.

We do not regard the licentiate as "an imperfectly" or "hastily manufactured" doctor. It is true that his training is not as complete as that of the basic doctor, but it has enabled him to render meritorious service in the past. Several distinguished medical officers have now, during our discussions, expressed the opinion that by suitable modifications in the curriculum an effective medical training can be given in 3½ years, including a six months' internship.

Our colleagues have been strongly influenced by the recommendations of the Goodenough Committee in the United Kingdom. While acknowledging the authoritative nature of that Committee's report, we must point out that it deals with a highly industrialised and developed country where conditions differ widely from those in India. In our view, the experience of the U. S. S. R., where conditions are comparable with those in India, is a more helpful guide. Remarkable progress in the provision of public health and medical relief services to the people of that vast country has been made in the last 25 years. During the greater part of that period, the training of medical personnel was undertaken on a mass scale, by utilising unorthodox methods and accepting wide variety in the duration and standards of the courses prescribed. The result was that while in the years 1928 to 1932, the output of doctors was 42,000, during 1933—37 it had increased to 99,600; and other types of trained personnel showed similar increases. Thus, in 1938 it was possible for the authors of the Third Five Year Plan to place in the forefront of their programme, the improvement of the quality and standard of training and a steady increase in the higher grade medical schools.

This experience suggests to us that we should be prepared to use every possible means in India, including the adoption of a shorter licentiate course, to increase, both rapidly and substantially, the production of trained medical personnel. Once the output of such personnel has sufficiently increased, then it will be possible to place greater emphasis upon the quality and length of training and to insist upon the production of basic doctors only. Such a policy would make possible the fulfilment of both the short and the long term programmes at an earlier date than is at present envisaged in this report. In fact it would speed up considerably the progress of all our schemes.

We recognise that the U. S. S. R. has a highly centralised and authoritarian government which is able not only to plan but also to execute the plan it has made. In India, on the other hand, the adoption and execution of our plans and programmes will be mainly the responsibility of Provincial Governments. We can only therefore express the hope that they will share our view that the imperative and fundamental need in India is the large-scale production of trained medical personnel of all kinds, in as short a time as possible, and that this may necessitate the toleration, for the time being, of lower standards and shorter courses of training than they would ordinarily prescribe. Such a policy will be fully justified if it results in really rapid and substantial improvement in the health services of the country.

F. E. JAMES.  
VISHWANATH.  
P. N. SAPRU.  
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L. K. MAITRA.  
A. H. BUTT.



## II

One fifth of this planet's population is cooped up in India. One-tenth of this population lives in cities and nine tenths is dispersed over six lacs of villages. The medical service of the people, poor enough in urban areas, is deplorably deficient in rural areas. The country as a whole possesses but one tenth the number of doctors she should have if Western standards of medical service prevailed. This enormous deficiency is further aggravated, so far as the rural population is concerned, by nine tenths of the available doctors concentrating in the cities and only one tenth being left to serve the vast rural population of this subcontinent. Poor communications and economic want interfere greatly with free utilisation of even this very meagre personnel.

Nearly two thirds of the total number of registered medical practitioners in India are Licentiates and the rest graduates. The former have been an important indigenous feature of the growth of Western medicine in India and no section of the profession in the country have greater service of humanity or medical science to its credit. There is no doctor of eminence from the non-licentiate group whose compeer or better could not be found in India from amongst the licentiates. They occupy through their merit and service a place in the affections of our people to which unbiassed citizens from all strata of Indian society, particularly rural, would gladly bear testimony.

The question of post-war improvements in medical education, has been considered recently in England by the Goodenough Committee. Two classes of medical practitioners, licentiates and graduates, have existed in England, as in India, for over a century. The Goodenough Committee has recommended the abolition of licentiate teaching in England. This recommendation has influenced greatly several members of our Committee. In a hurry to conform they have unfortunately ignored the fact that the Goodenough report describes the proposed abolition of licentiate teaching as the "final stage" of an "evolutionary development". We are of the opinion that that final stage of evolutionary development is not one of India's achievements yet. Neither in the medical sphere nor in the more fundamental spheres of economic, social or political organisation, can India claim to have attained the evolutionary development that the Goodenough Committee Report claims for England. From the point of view of medical development, India is said to stand today where England stood 100 years ago. The U.S.A., 75 years ago and Russia in 1917. England was in no hurry in the last 100 years to abolish the production of licentiate doctors, why should India be coerced to take this step on the eve of momentous changes in its future?

An important feature of evolutionary development in England was progressive urbanisation. Only 20 per cent. of England's population was rural before this war. It is 90 per cent. in India. England with her high urbanisation percentage, is only contemplating giving up Licentiate production now. If Japan with 50 per cent. urbanisation of her population stuck to Licentiate production, if Russia with vast stretches of territory and a vast rural population has perfected rural medical relief by strengthening enormously her production of Feldshers (medical assistants), why must India abandon a well tried and useful institution?

The following paragraphs answer arguments cited on pages 340-41 of this report:—

As for argument (a) on page 340, we must state that we consider that our licentiates, *vis-a-vis* our graduates, represent the same range of medical competence as the licentiates and graduates in England. One may, if one wishes to indulge in unnecessary comparisons, designate groups as more or "less completely trained" but after one has begun medical practice the label may soon shift. The licentiate may prove, as he not unoften does, more completely trained than the graduate.

The central fact to realise is that our requirements are so vast that there is full room for all types of medical personnel in our country.

In "a statistical study spread over 6 years in Bhopal State, it was found that 88 per cent. of the total ailments were amenable to simple treatment, if given in time, that 13 per cent. needed hospital care, and that 4 per cent. required specialised treatment". This investigation suggests a range of usefulness for licentiates which must make opposition to their employment at primary and other centres a pure exhibition of prejudice.

So far as "the temptation to increase numbers by lowering the standard of teaching" is concerned, the Russian example is worth close study. There are phases in the programmes of development of backward countries, which may demand varying emphasis on the quantitative and qualitative aspects of achievements, at different times and under different conditions. Within limits standards can be made to suit dominant requirements. The contemplated "basic doctor's" training is about the same as that of a medical graduate in Russia and within 20 years that country has raised her number of graduates from 19,000 to nearly 1,40,000. Simultaneously they have produced 3.6 Feldshers for every doctor trained. We have in India 2,500 out-patient dispensaries which are mostly in charge of licentiates. Russia has 48,000 dispensaries, the independent charge of which is held by Feldshers.

As to para. (b), the practice of community and preventive aspects of medicine has a range, like other applied sciences, within which the licentiate can usefully function. The licentiate is quite competent with a small orientation course to do justice to these particular aspects and this teaching can also be fitted into his undergraduate curriculum without trouble. The community and preventive aspects of medicine are merely the applied aspects of fundamental sciences which are to a substantial extent integral parts of the existing curricula of licentiate teaching. The rest of the arguments in this paragraph and in paras. (c), (d) and (e) are an explanation of the dangers attending the production of more than one category of doctors. If there be any force in these prognostications, Russia—the foremost exponent of the utility of the two grades of medical personnel—should have been ruined from a health point of view. On the contrary, its perfection of public health and medical services, working for its rural and urban population and the Army, have been the envy of the whole world. She has raised the number of medical colleges, which were eleven in the Tsarist regime, to seventy-two and medical schools from sixty-five to nine hundred and eighty-five.

The argument to create a classless profession to eliminate inferiority complexes, looks superficial, when read in the context of the rest of the Report, the organisation section of which gives ample evidence of hierarchies, insuring perpetuation of the complexes denounced.

So far as the demand on the part of the Licentiates for the abolition of their class is concerned, its genesis lay in the failure on the part of the administration in the past, to attend to their genuine grievances. Rather than remove these the group has been encouraged to commit suicide.

The consequences of licentiate discontent are not to be borne by agencies concerned with the genesis or continuance of the discontent, but are to be visited on the dumb millions of the countryside, who are to be deprived of licentiate service.

A similar situation had arisen in Russia. Although Government of that country had also very nearly ordered the abolition of this class but before final orders were issued, a scientific examination of the demand was ordered. It was found that grave injury to public health and medical relief would result by the abolition of this class. Orders were consequently issued to increase the number of Feldsher Medical Schools which were gradually raised, from sixty five in 1915 to nine hundred and eighty five in 1941.

So far as the argument of the support of the two Congress Ministries to the abolition of this class is concerned, it must be stated that the step was taken first in Madras where the medical portfolio came to be held by a Licentiate Minister. The U.P. followed this lead unthinkingly, for it was the province with the poorest arrangements for rural medical relief in India and needed licentiates most. Its Governor when interviewed by members of the Health Survey and Development Committee, who toured his province, deplored the abolition of licentiate teaching in his province. Further this matter could not have been considered by the Central Organisation of the Congress. Its members claim to be friends of the poor. How could they give precedence to the demand of a Trade Union like the Licentiates Association, priority over the interests of the rural masses? It is difficult to imagine, that looking about for world experience, Messrs. Gandhi, Nehru or Azad, could have ignored the positive achievements of Russia in this field.

Note must be taken of the fact that while a majority on the Health Survey and Development Committee can abolish the licentiate, they cannot prevent other practitioners, practising a variety of systems of medicine, taking his place. This has already happened in Congress Provinces, particularly those which have banned licentiate teaching. So far as indigenous systems of repute like the Ayurvedic and Yunani are concerned, their teaching is passing on to institutions which combine elementary courses of training in basic subjects of the medical curriculum with Materia Medica and Therapeutics of the indigenous systems. Sociology and economics often determine the patient doctor relationship. Under existing conditions the licentiate will be replaced mainly by Vaidas and Hakims. Already hundreds of them are being employed by Government for inoculation work etc. previously done by medical men. This will raise the question of the extent to which these systems will have a claim on Government support. The virtual shelving of this question by the Health Survey

and Development Committee will be no help when the actual application of crores of public money to problems of health and medical relief takes place in the provinces and at the centre. The "basic" doctor will not willingly fit into the rural scheme, except under conditions of destitution.

Since the scheme proposed for Medical Relief and Public Health is to benefit only a section of the population (one fifth for the first three years and one half slowly in 10 years) and is supposed to absorb the entire output of all the existing Medical Colleges as well as the sublimated Medical Schools. Public Health and Medical Relief over the remaining four fifth to one half of the country, for which no medical colleges or schools will work, will atrophy. There will be no personnel like the licentiates even, to help the regions and institutions which will come under neglect. The chaos created by the end of ten years need not be considered, for the country by then would have entered the period of the long term programme, the details of which like those of other millenia, must of necessity remain nebulous.

The decisions of bodies, like the Health Survey and Development Committee, are often taken not so much on facts garnered or their evaluation, but on ideologies which dominate the minds of the members. They must have the Goodenough Committee findings prevail, even though there be so little common between the educational, economic, political or medical development of England and India. Russian experience and achievements must be ignored, nay rejected, even when the fate of institutions common to both Russia and India, such as medical schools for licentiates, was concerned.

Lt.-General J. B. Hance and Lt.-Col. D. P. McDonald published a memorandum for the consideration of our Committee in which they said "The basic problem is now to raise 260,000 doctors, 770,000 nurses, 69,000 Health Visitors and 85,000 Midwives. For the answer we should not look to the prosperous and highly civilised communities of the United Kingdom and United States of America for our models. Our difficulties are shared by Russia and China". According to these officers there was in Russia "A realisation that they could not dispense with the Feldshers".

But the Health Survey and Development Committee decide that India must dispense with this class. They fear to emulate the Russian example.

Our specific recommendations are as follows:—

1. Keeping in view the very urgent need for doctors and more doctors we are strongly of opinion that the production of Licentiates should continue till the increased number of Medical Colleges has produced "basic" doctors in the proportion of at least 1 to 1,500 of the population. Until such time, provinces must not be coerced into closing the existing medical schools.

2. That the existing course of medical studies for licentiates should be considered as closely from the point of view of economics in and reinforcements of the curriculum, as already done by the Committee in respect of University courses of medical education. In our opinion this consideration can help to reduce the licentiate course from 4 to 3 years plus a period of internship for six months.

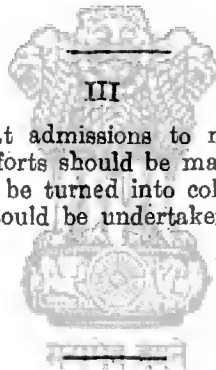
3. The number of students obtaining the F.Sc. Medical qualification in India is so great that this qualification could be demanded as basic for purposes of admission to the Licentiate course. This will facilitate the acquisition, later of the University qualifications by Licentiates who so desire.

4. The licentiate course can be oriented for purposes of Public Health bias along same lines as recommended by the Committee for the courses of instruction for medical graduates.

5. The decisions taken by the Medical Council of India, enabling Licentiates to acquire medical qualifications of the University standard, during the pendency of the war and for three years after should be further liberalised and made permanent. Provision should also be made for the admission to Medical Colleges of all Licentiates who wish to attend supplementary courses of instruction to obtain medical degrees. The cruel slogan "once a licentiate always a licentiate" must be killed, but with it not the Licentiate whose services to this country have been, and may yet be for a considerable time, of inestimable value.

VISHWA NATH.

A. H. BUTT.



We strongly feel that admissions to medical schools should be stopped forthwith and efforts should be made to upgrade such of the medical schools as could be turned into colleges. The improvements in the existing colleges could be undertaken afterwards.

R. A. AMESUR.

U. B. NARAYANRAO.

H. R. WADHWANI.

## **B. PROPOSALS IN RESPECT OF THE EDUCATION OF HEALTH PERSONNEL**

### **(i) MEDICAL EDUCATION**

#### **Undergraduate Education**

1. There is a great need for a reorganisation of the standards of professional training in order to provide the types of workers who will be fully equipped for participation in a modern health programme with its newer and expanding conception of service to the community. From a study of modern trends it became evident to us that what was really required was a reorientation of outlook. Whereas, up to the present, there has been a division of medical duties into (a) preventive and (b) curative, the need of the future is quite definitely for a type of doctor who will combine both of these functions in his own person—a "basic" doctor. It must be borne in mind that these remarks apply mainly to the type of relief which will be given in the primary units. In the institutions at the secondary health centres and district headquarters, there will be a separation for specialization, but again at the highest administrative level, there will be a fresh fusion into a Director, whose sphere of duty will cover both the preventive and curative fields.

2. The conception of a "basic" doctor is not new. Some ten years ago Dr. Etienne Burnet of the Pasteur Institute prepared for the League of Nations a Review of Medical Education and the Reform of Medical Studies. In the course of that review he asked the question "What type of doctor do we wish to produce?" In his answer he quoted from Professor Hernado of Madrid "We do not think that the family doctor is disappearing or that he should disappear. He will be a preventive medicine hygienist, he will be a vaccinator, the detector of diseases at their outset, the supervisor of convalescents and germ carriers, the agent of systematic examinations. He will require a culture and a skill superior to that demanded of him now". Medicine, Dr. Burnet said, having only too much to do in this field has for a long time past concentrated on the art of curing disease. It is time for it to devote its chief attention to the art of preserving, or even of creating, health. This will not be a sudden revolution. The creators of rational medicine realize that health has priority over sickness and should be studied *for its own sake*. Hygiene has always existed in embryo side by side with medicine. From Sir Arthur Newsholme he drew the following contribution—"The first desideratum for the doctor who wishes to enter into the world of new medicine is a full acquaintance with the normal and a complete knowledge of means for its maintenance." Dr. Burnet, supporting himself further by so eminent an authority as Sir George Newman, gave emphasis to the principle that the idea of preventive medicine should permeate the whole of medical education. The reason why preventive medicine has not, up to the present, become inter-related with clinical studies is that it has been taught largely by public health officials. If the practitioner is to practice preventive medicine he must be taught that subject by his clinical professors. Preventive medicine leads easily to social medicine, and it is as exponents of the principles of social medicine that we would wish the "basic" doctor to go forth into the world of medicine.

3. Considerable thought has been given by us to the type of training necessary for the evolution of this "basic" doctor, and advice was sought from a strong and representative advisory panel of experts before setting out the recommendations which will be found detailed at some length in Appendix 28.

4. The main ideas underlying the changes recommended in the undergraduate curriculum are as follows:—

(1) Emphasis in undergraduate teaching will be on the inclusion of principles and methods which would enable the student to learn for himself, think, observe and draw conclusions.

(2) Throughout his career the student will be made to realize that general science and medicine have many points of contact and that they are both continually progressing.

(3) Every effort will be made to exemplify this principle by the inclusion of clinical teaching in the pre-clinical period, given by a clinician who will bring living reality into what often tends to be a dead and purposeless study. Similarly the teaching of pre-clinical subjects will not end with the passing of examinations, but will extend into and throughout the clinical years by regular courses given not informally by clinicians, but by the regular teachers in the pre-clinical subjects.

(4) In the teaching of anatomy the number of didactic lectures should be radically curtailed and the number of lecture-demonstrations should be increased, with smaller classes than is usual at present. In the teaching of physiology, the syllabus should be similarly revised.

(5) Throughout the recommendations, reduction in the size of classes as compared with the present and increase in the number of teachers is stressed. The proportion of instructors to students is a matter of considerable importance. In pre-clinical subjects the ratio of instructors to students should be approximately 1 : 15. In the U. S. A., this proportion ranges from 1:2 to 1:12, with an average of 1: 4. It is most important also that mechanical equipment such as microscopes, haemoglobinometers etc. should be adequate.

(6) Towards the latter half of the pre-clinical studies a course of lectures in elementary psychology and elementary pharmacology should be introduced as well as an introduction to the study of pathology.

(7) At the beginning of the clinical period, a short course of instruction should be given in the methods of clinical diagnosis and laboratory technique, the elements of nursing and dietetics, and an introduction to the subject of social medicine.

(8) In the clinical subjects, which will be taught mainly by whole-time teachers, every effort should be made by means of regular conferences, at which the various teachers should be present, to show the students that medicine, surgery and pathology are not separate subjects in isolated compartments, but that all form parts of one whole.

(9) In clinical work in the wards every effort should be made to give as much personal attention to the students as possible. The number of beds in a unit should be at least 40 and 8 or 10 students should be attached to each unit. The proportion preferably of junior teachers to students should be 1: 8 and of senior teachers 1: 10.

(10) In the teaching of pathology, which should be revised and extended so as to include more definite instruction in Microbiology and Parasitology, great importance should be attached to post-mortem work. The physician and the surgeon concerned should attend the post-mortem with the students and participate with the pathologist in the discussion on the post-mortem findings. If necessary, State legislation should be introduced to make an autopsy obligatory, if it is considered necessary by the medical staff.

(11) In every teaching institution a department of Preventive and Social Medicine should be organized on the lines set out in Appendix 29, with facilities for both teaching and field work. In the meantime the preventive aspect of medicine should be stressed in the teaching of every subject throughout the clinical course, and the student given an insight into Social Medicine by contacts with home and community life. A hospital social service should be established as soon as trained personnel become available.

(12) We do not wish to attempt to impose upon the country a stereotyped curriculum so long as the fundamental details of our recommendations are observed. We consider that a wide margin should be allowed to individual medical colleges and universities to

develop their own potentialities, and even to experiment, provided that the obligation to conform to certain known minimum standards is met. We hold that reforms and improvements are more likely to be brought about in that way, for where reforms have to await agreement among a large number of institutions, the result is usually delay in progress.

(13) It is considered essential that, after the final qualifying examination at the end of the fourth year, there should be for every student one year's "internship", during which time he should work under supervision and not be given the full rights of a practitioner. There should be sufficient latitude given to the authorities concerning the manner in which this year should be spent, but it is essential that in every case, three months should be devoted to work in a public health unit.

(14) Throughout the whole period of the course the importance of research should be stressed. The whole-time teachers will themselves be expected to engage in research in their subject and will also be required to encourage any student who shows any aptitude or leaning towards this most important aspect of his work.

5. *Annual entry of medical students.*—With a view to obtaining a standardized medical education our fundamental recommendation for the short-term scheme is that existing medical schools shall be gradually closed down as schools, and, so far as possible, be converted into colleges, while existing medical colleges shall be improved and expanded so as to take in a larger number of students annually.

6. At the present time an average of 1,200 students are admitted each year into the various medical colleges while the medical schools absorb a further 1,000 to 1,200. The total number of students at present catered for is, therefore, in the region of 2,400. We feel that if effective steps are taken, the annual entry into the 16 medical colleges existing at present can be increased from 1,200 to at least 1,920. We would, however, emphasize that such increase should be given effect to only when radical alterations have been made in the laboratories, lecture halls and hostels, and adequate provision made for the teaching of personnel required for each institution. In spite of the fact that most of the medical colleges are understaffed and that their Departments will have to undergo radical changes, we believe that as a first step it should be possible, with sufficient financial aid, for changes to be made simultaneously both as regards increased efficiency and also as regards extending the scope of work so as to permit an increase in the number of students admitted.

7. As a guide to the authorities concerned in the organisation of Medical Colleges on the lines recommended by us we give in Appendix 30 certain recommendations regarding estimates of staff put forward by the Goodenough Committee.

8. *The planning of teaching centres.*—It has to be borne in mind that some provinces are in a much better position than others to open new medical colleges. In the establishment of new medical colleges, therefore, it seems necessary to bear in mind the requirements of the latter provinces and to concert measures whereby a certain proportion of seats may be reserved for candidates from such



areas with a view to spreading out medical education and making it available equally to the whole of India. This can be facilitated by the Central Government taking a share both in the establishment of new medical colleges and also in the financial responsibility for their efficient maintenance.

### **Detailed Recommendations regarding Teaching Institutions for the Training of Undergraduates**

9. (a) *Improvements in existing colleges.*—It has been pointed out in the survey section of this report that grave defects exist in most of the existing medical colleges and we recommend that every effort should be made to bring those colleges up to the standards which are defined under the heading "The Requirements of a Medical College" in the Memorandum contained in Appendix 28.

As has already been noted, that memorandum is integral to any large scale adoption of these proposals, and its recommendations are of uniform application. In particular, we would like to draw attention to the fact that considerable improvements are needed in the Agra Medical College, in the Balak Ram Medical College at Lahore, in the recently opened Medical College at Cuttack, and in the Amritsar Medical College opened by the Punjab Government, before they can be considered as satisfying the requirements of a Medical College. The Stanley Medical College, Madras, and the Missionary Medical College at Vellore also require extensive improvements. In the Stanley Medical College, immediate steps should be taken to provide for the Departments of Anatomy, Physiology and Biochemistry within the College proper, to remodel thoroughly the lying-in-hospital and the out-patients department of the Stanley Medical Hospital and to improve the facilities available in its special departments. The Vellore Medical College authorities, it is understood, are launching a large scheme of radical reconstruction with the intention of making the college a co-education mission institution to admit a hundred students every year. There is another school, the Arya Medical School at Ludhiana. We consider it desirable that there should be a medical college for this area of the Punjab and suggest the conversion of the latter medical school into a college. Some of the Departments of the Calcutta Medical College and the Carmichael Medical College stand in need of improvements and reference has been made to this in the reports of the Inspectors of the Indian Medical Council. The Madras Medical College, which affords extensive facilities in many branches of study, suffers unfortunately from the fact that the associated hospitals are too spread out, with the result that the time of the students is wasted in journeying to the Maternity Hospital and the Ophthalmic Hospital about two miles away, the Tuberculosis Hospital which is at an equal distance, the Infectious Diseases Hospital and the Mental Hospital which are both five miles distant from the General Hospital.

10. This is a convenient place in which to draw attention again to the desirability of having all the special departments as far as possible situated in the same campus as the General Hospital. For obvious reasons, this will at present not be possible in most of those Medical Colleges which are already in existence, but we believe the principle to be sound and urge that it should be borne in mind in the construction of new medical colleges.

11. We advise that the maximum yearly admissions should be normally 100, although, during the short-term programme, it is suggested that admissions might be raised to 120 in order to help in the production of as many qualified medical men as possible. This would, however, be a temporary expedient. It must be realized that any number in excess of 100 may lead to a loss of personal attention to individual students and to overcrowding in laboratories etc.

12. In practically every teaching hospital, considerable additions are essential both in equipment and additional accommodation for patients, while an increase in the number of teaching staff and the appointment of whole-time teachers, and of a large number of trained sisters, nurses and technicians and of an adequate secretarial staff are all urgently required. Quarters for the house staff, for the nursing staff and the resident students will have to be built in most of the teaching centres.

13. (b) *Conversion of existing Medical Schools into Colleges.*—We are of opinion that given sufficient funds, it should not be difficult to convert the following medical schools into colleges:—

1. The Poona Medical School.
2. The Ahmedabad Medical School.
3. The Darbhanga Medical School.
4. The Campbell Medical School.
5. The Calcutta Medical School.
6. The National Medical School.
7. The Dacca Medical School.
8. The Jalpaiguri Medical School.
9. The Nagpur Medical School.
10. The Medical School, Bangalore (Mysore).
11. The Indore Medical School for Central India and Rajputana States.
12. The Arya Medical School, Ludhiana.

14. (c) *Establishment of new Medical Colleges.*—For obvious reasons, namely population, wealth and progress there are considerable variations in the ability of different provinces to establish new medical colleges. We have, in considering this question, borne these matters in mind and also the fact that provision may have to be made for students from outside a province. The suggestions which we now advance must not be considered as in any way final. They are the best that, with the information at our disposal, we are able to put forward.

15. It is now proposed to consider the Provinces and States separately.

(1) *Madras.*—There are at present four Medical Colleges in Madras, and no schools remain to be converted. This province should within the next 10 years be in a position to establish colleges at Madura, Coimbatore, Guntur, Cocanada and Calicut. A distribution such as this will spread the new facilities over the province, and will run parallel to the long-term policy which is envisaged for medical relief there. We would like the question of a college in the Ceded

Districts to be considered, either supplementary to or in place of one of the colleges suggested above. It is felt that at least two of the colleges, each admitting 100 students, can be started immediately, and that the other three can be planned within the next five years.

(2) *Bombay*.—Bombay has at present two medical colleges, and the conversion of the schools at Poona and Ahmedabad will bring the number to four. Bombay city affords abundant clinical material justifying the establishment of more colleges, and we propose that at least two more should be provided at an early date. We suggest one more college for the southern part of the province.

(3) *The Central Provinces*.—The conversion of the school at Nagpur into a college is a matter of urgency. We consider that the existing buildings will not be suitable and that an entirely new college and hospital should be constructed either within the area or the existing buildings, or in an area which may be defined by the Improvement Trust. An area of between 50 to 100 acres should be insisted on. It is suggested that, when these recommendations have been given effect to, a college should be established at Jubbulpore.

(4) *Orissa*.—The school at Cuttack has recently been converted into a college, but in order to come into line with the others, radical alterations and improvements will be required. It is not possible for this province to consider the establishment of any other college.

(5) *Bengal*.—The clinical material in Calcutta is unquestionably the richest in the whole of the East and, at present, the strength of 4,000 beds for a population of nearly 2½ millions is totally inadequate for a centre of such importance. There should be a bed ratio of 6 to 8 per thousand of population instead of the existing ratio 1 to 600.

The Campbell Medical School is inadequate as a training centre according to modern standards and we consider that nothing short of the demolition of a large part of the School and the entire re-modelling of the Hospital will enable this institution to be converted into a medical college suitable for the intake of a hundred students per year.

The National Medical School which is a private organisation is situated in an area where there is great need for medical facilities. We suggest, therefore, that the extensive area around this School should be acquired and the School converted into a College at an early date.

The above improvements will add two colleges to the two already existing, and it is proposed that, in addition, the erection of two entirely new colleges should be undertaken within the next five years. In that way at the end of 10 years, there should be facilities for the training in Calcutta of 600 students per year.

In addition to those metropolitan colleges, we recommend that in the province of Bengal, colleges should be established at Dacca, Burdwan and Jalpaiguri.

(6) *Bihar*.—The existing college at Patna should be improved and extended so as to take in 100 students. The Medical School at Darbhanga should be converted into a College.

(7) *United Provinces*.—The two existing medical colleges at Lucknow and Agra require improvements and extension so as to

take in the full number of students. We propose that, during the short-term programme, colleges should be established at Allahabad, Cawnpore, Benares and Aligarh. The Hindu and Muslim Universities at the last two places serve an all-India purpose and attract students of the respective communities from all parts of the country. Medical colleges established in these two places can therefore serve the needs of India as a whole and it is for this reason that we would welcome the establishment of medical colleges fulfilling the requisite standards of efficiency at these universities.

(8) *The Punjab*.—We advise that activities in this province should be concentrated on improving colleges which have already been opened. Lahore, Amritsar and Balakram colleges all need remodelling and extension. The possibility of opening one more college in this province can be considered after these three colleges have been strengthened so as to receive the maximum number of students. We have already recommended that the Arya Medical School at Ludhiana should be converted into a college.

(9) *Sind*.—We recommend the closing of the school at Hyderabad and the opening of a new college at Karachi.

(10) *Assam and the North-West Frontier Province*.—We hope that it may be possible for these two provinces to establish medical colleges at an early date. Until this is done our recommendation is that some of the colleges proposed for the neighbouring provinces should, for the present, give facilities for students from these two provinces who desire training in medicine.

(11) *Delhi*.—The Lady Hardinge Medical College, Delhi, is the only institution in India offering medical education exclusively for women.

(12) *Ajmer*.—We consider the establishment of a new college at Ajmer of the utmost importance. The whole of the Rajputana area has no facilities for medical education. We recommend that a certain proportion of the seats in the proposed medical college should be earmarked for students from the different Rajputana States and that the latter should be asked to contribute towards the capital and recurring expenses of the college.

(13) *Indian States*.—We have no desire to do more than offer helpful suggestions in this as in other matters germane to the health of the people, for the consideration of the Indian States. We feel that infinitely more valuable results can be achieved by co-operation between Governments than can possibly follow from isolated independent effort and hope that the ideas which we set out here and elsewhere in this report may be found of some use by those in the Indian States with whom rests the responsibility for action in the field of health.

We have stressed the prime necessity for the maintenance of the standards of medical education at a high level and subject always to this basic requirement, we feel that the States have it in their power to extend facilities for sound medical education to a very material extent. It may be that a number of States may feel it advisable to join together to bring institutions adequately equipped and administered for this purpose into being to serve their needs. Others may find it more suitable to make arrangements with a

neighbouring Provincial Government for such a purpose. We feel, however, that there is a number of individual States whose resources, high standards of administration and interest in the well-being of their peoples eminently fit them to make a very effective contribution to the solution of what is really an all-India problem by having their own medical teaching institutions. For it must be borne in mind that the doctor and other medical personnel required by the States, if these cannot be supplied by the States themselves, may eventually have to be drawn from the limited numbers available in British India which must, therefore, be vitally affected. We feel that, provided standards are maintained at the level which we visualise, a number of new medical institutions could, with advantage to all, be brought into being in the States, while existing institutions could be brought up-to-date and enlarged. The Medical School at Indore if raised to the status of a College would prove of invaluable service to Central India. Mysore could enlarge the college at Mysore and bring another into being at Bangalore. With its resources, it could ensure that both are up-to-date and in accordance with the highest modern requirements, while Hyderabad could certainly enlarge its existing college to take in 120 students annually while making it, through proper equipment and staff, second to none in India.

16. If all the above colleges work at their full strength the total annual intake of students would be between 4,500, and 5,000. This is the objective which we wish to be kept in view for the short-term policy. We are not able to give concrete long-term proposals and feel that rather than build upon an insecure foundation, we prefer to advise a review of the position at the end of five or seven years, by which time there should be more information available for facilitating planning on a sounder basis.

#### **Postgraduate Education**

17. Except for the institution of courses of instruction leading to the degrees of M.D., and M.S., few of the universities have, until recently, evolved any extensive scheme for the improvement of postgraduate medical education. Within the last year or two, however, there has been a move by certain universities towards the establishment of diplomas in special subjects as well as higher degrees in medicine. But this step, while admirable in itself, does not attack the problem of postgraduate training at its roots. It may tend towards the sterile acquirement of degrees and diplomas as a sort of personal adornment, often without either the intention or the ability on the part of the recipient to specialise. There should be a clear understanding by the profession, and also by the public that, for recognition as a fully qualified specialist, four or five years should have been spent in the study of the speciality in a large teaching centre, where facilities are available not only for instruction and the acquisition of knowledge, but also for the conduct of research.

18. Postgraduate education should be devised to meet two different needs, each important in itself but not connected with each other. They are :

- (a) The training of consultants and specialists.
- (b) The training of practitioners desirous of practising a speciality, without the definite status of specialists.

In the case of (a) such training will naturally involve several years of work in special departments or hospitals under the guidance of a consultant or a specialist. The training may extend up to five years and lead to a higher qualification, such as M.D. or M.S.

In the case of (b) the training will be in the speciality for a period ranging from 12 months to 18 months under suitable guidance.

Courses should be available in :

- (i) Oto-Rhino-Laryngology.
- (ii) Dermatology.
- (iii) Radiology, diagnostic and therapeutic.
- (iv) Ophthalmology.
- (v) Obstetrics and gynaecology.
- (vi) Venereology.
- (vii) Anaesthesia.
- (viii) Psychiatry.
- (ix) Pediatrics.
- (x) Tuberculosis.
- (xi) Malariology.
- (xii) Blood transfusion and resuscitation.
- (xiii) Orthopaedics.

At the end of the course, the candidate should be eligible for a diploma in the speciality. Before he engages in study for the higher degree or diploma it should be a pre-requisite that the candidate should have completed his internship for one year which all persons will, under our proposals, be required to undergo after passing the qualifying examination. Resident appointments in the specialities should be available to graduates only after they have completed this period of internship.

19. *The technical and administrative control of postgraduate medical education.*—We have given considerable thought to the question of developing facilities for postgraduate teaching and research in different parts of the country. In the chapter dealing with the All-India Medical Institute it has been suggested that this institution should provide postgraduate training of a high order in a large number of subjects in medical and certain allied sciences. At the same time it will be necessary to supplement these facilities by the development of existing or new institutions at suitable places in the provinces and to make them centres for training on an all-India basis. These will fall under two heads, namely, (1) special institutes for particular diseases such as leprosy and (2) provincial centres where existing facilities in certain branches of medicine can be extended in order to make them available not only to the province concerned but also to other parts of the country.

20. We think it undesirable that every centre of medical education in India should attempt to give courses of advanced training in a large number of subjects. We feel that it would be more in the interest of real specialisation if universities were to offer advanced courses only in those subjects for which they have particularly good facilities. Clinical material varies in nature in the different provinces in India and it is evident that where material is abundant for the

study of a special disease, a centre should be established there, aiming at a high level of instruction in that subject.

We have in view the possibility of such large postgraduate centres being instituted in Midwifery and Ophthalmology in Madras, in Ophthalmology and Tropical Medicine in Calcutta, in Pathology and Bacteriology and possibly Midwifery in Bombay. The Tata Memorial Cancer Hospital would undoubtedly be a rich treasure-house for postgraduate training in the Pathology of malignant diseases in addition to General Pathology.

21. We recommend that, as all these institutions will serve the needs of the country as a whole, the Central Government should contribute a share towards the cost of developing and maintaining them. The province concerned and the other provinces, which will be benefited by the training facilities that are offered, should also bear their respective shares of the financial burden. The question of apportioning the cost will be discussed later. In the meantime it will be recognised that, when facilities for postgraduate education are to be developed on such a basis of co-operation between the Central and Provincial Governments, questions relating to the administration and technical aspects of the control of education will have to be considered with care. We shall deal first with the technical aspect.

22. *The technical aspect.*—We consider it essential that a high standard of postgraduate teaching and research should be developed in these institutions. In this connection it may not be out of place to mention that the Goodenough Committee has stated that the position in regard to postgraduate diplomas in the United Kingdom, excluding the fellowship and membership diplomas of the Royal Medical Colleges, is unsatisfactory, that a considerable variation in standard exists in respect of qualifications in the same subject and that many of the diplomas have encouraged "ill-grounded and immature specialisation". In these circumstances that Committee has recommended that the award of all postgraduate medical diplomas, with certain exceptions, should be undertaken by the Royal Medical Colleges. We are particularly anxious to avoid the development, in India, of such conditions as have been pointed out by the Goodenough Committee in respect of postgraduate diplomas in Great Britain and we therefore suggest the creation of a special organisation for advising the Central and Provincial Governments on the control of the postgraduate medical training centres we have proposed. This body may be designated "The Central Committee for Postgraduate Medical Education". We shall deal with the composition of this organisation later. Before doing so we shall first state our reasons for recommending the creation of a special body for the purpose.

23. It may be asked why the function of supervising postgraduate education should not be entrusted to the Indian Medical Council which has been created "in order to establish a uniform minimum standard of higher qualifications in medicine for all provinces". At present the Indian Medical Council exercises supervision over the universities granting certain medical qualifications given in the first Schedule of the Indian Medical Council Act, which consist of the university degrees which qualify for practice as medical men and for certain higher qualifications in medicine, surgery and obstetrics.

The Act provides for the addition of other qualifications to the First Schedule so that the inclusion of the new postgraduate diplomas that may come into existence presents no difficulty. We, however, doubt the wisdom of adding these new functions to the existing duties of the Indian Medical Council. Under our programme of expansion of undergraduate medical education the number of medical colleges requiring supervision by the Indian Medical Council will increase considerably. We therefore consider it wiser to limit its functions to those already entrusted to it by the Act than to enlarge them so as to include the various new types of diplomas that will come into being through the expansion of postgraduate education. Its present functions include supervision over such qualifications as the Masterships of Medicine, Surgery and Obstetrics.

24. The Goodenough Committee has suggested, for the United Kingdom, the transference of control over postgraduate diplomas, with certain exceptions, to the Royal Medical Colleges. In that country the supervision of undergraduate medical training is vested in the General Council of Medical Education and Registration. The latter was established by the Medical Act, 1858, of that country for the purpose of enabling persons requiring medical aid "to distinguish qualified from unqualified practitioners" and its powers of supervision of medical education are limited to undergraduate teaching and to the examinations which qualify for admission to the Medical Register, whether these be conducted by universities or other licensing bodies. Supervision of postgraduate teaching does not appear to come within the range of functions of the General Medical Council in Great Britain.

25. The position of the Indian Medical Council is somewhat different. It has not been authorised by law to maintain an All-India Medical Register or to exercise supervision over the various types of basic medical qualifications that exist in the provinces for obtaining entry into the Provincial Medical Registers. These are at present responsibilities entrusted to Provincial Medical Councils and Faculties. The supervision of the Indian Medical Council is restricted to certain medical qualifications which are granted by Indian Universities and which are incorporated in the First Schedule of the Indian Medical Council Act. We consider the present position unsatisfactory and have discussed the matter in detail in another section of this report. Without going into that discussion here it may be stated that, in view of our recommendation for only one basic qualification throughout India for entry into the profession, we have recommended that the Indian Medical Council should maintain an All-India Register and that it should supervise undergraduate medical education, which will be confined to institutions affiliated to Universities, throughout the country. In this way its functions will approximate closely to those of the General Council of Medical Education and Registration of the United Kingdom. In view of the large expansion of undergraduate medical education we have recommended, we anticipate that the Indian Medical Council will find itself fully occupied with the task of ensuring that our suggestions for the improvement of undergraduate teaching and for its reorientation in certain directions are carried into effect throughout the country. In these circumstances we consider that there is considerable justification for the creation of a separate body for supervising postgraduate medical



education. As will be seen presently from the constitution that we are recommending for the proposed Central Committee, we are providing for two representatives of the Indian Medical Council on this body.

26. The question may be asked as to whether this proposed transference of power, to the Central Committee for Postgraduate Medical Education, for laying down standards in respect of postgraduate training in particular subjects, will not constitute an interference with the right of the universities to prescribe such standards in their own territories. In this connection it must be remembered that, in the field of undergraduate education, the powers of these universities have already been circumscribed by the right of the Indian Medical Council to regulate and control such education. We consider that, in the field of postgraduate education also, there should be some central authority for ensuring uniform standards of training. In attempting to secure such uniform standards some of us apprehend that, if minimum standards are prescribed, there may be a tendency to regard these as maximum standards and that such a tendency will not be conducive to the development of the highest type of postgraduate education. Due care will have to be taken to avoid such a possibility. We do not envisage that the functions of the Central Committee for Postgraduate Education will extend over the whole field of subjects in which postgraduate training can be given. We recommend that the Committee should concern itself, at least in the beginning, only with those subjects in which it is desired that facilities for postgraduate training, when provided in a provincial centre, should serve the purposes not only of that province but also those of one or more other provinces. There are no doubt many types of postgraduate training for which facilities exist in all parts of the country and we see no reason why the right of determining standards in respect of such subjects should not continue to be vested in the universities. We suggest that, in order to assist the universities in the organisation of such postgraduate teaching, a Postgraduate Council of Medical Education may be established in each university, on which should be represented members of the medical profession who are on the Faculty or Board of Studies in Medicine, a representative of the Provincial Government concerned and a representative of approved medical societies in the province. This Council will be responsible for regulating postgraduate education in the wide field that falls outside the suggested jurisdiction of the Central Committee for Postgraduate Education and will perform, among others, such functions as determining the subjects in which training should be given, arranging the courses, prescribing the syllabus from time to time and fixing the honoraria to be paid to lecturers.

27. *The administrative aspect.*—We envisage for the Central Committee for Postgraduate Education not only the function of technical supervision over postgraduate training in the institutions proposed to be established but also certain advisory functions in relation to their organisation and administration. These functions will include, in respect of both categories of institutions, namely, (1) institutes for special diseases and (2) existing provincial institutions which will be developed to serve as All-India training centres, the advising of the Central and Provincial Governments on the lines on which such institutions should be developed and the apportionment of cost, capital and recurring, between the different Governments. In the

case of institutes for special diseases, which may have to be started afresh, the Central Committee for Postgraduate Education will also be responsible for recommending the sites at which these should be established.

28. A decision regarding administrative control will be determined, to a large extent, by such matters as (1) the party or parties contributing to the expenditure involved in the maintenance of the institution concerned and (2) the authority that used to be responsible for its administration, if the institution be one which had existed previously and had been improved and enlarged to serve training functions on an all-India scale. It seems therefore advantageous to consider the institutions under the two categories separately.

29. (i) The institutions under category (1) above are for special diseases. As has already been pointed out, many of them will have to be established afresh or, even if certain existing facilities are utilised, the expenditure involved may be so considerable as to make the gain from the utilisation of these facilities inappreciable. In suggesting an apportionment of the cost it must be remembered that these institutions will provide postgraduate training facilities for all provinces. Even so, the services developed in connection with each of these institutions will serve the people of the local area in the province concerned, so that it seems correct to say that, on the whole, the latter benefits to a larger extent than the remaining provinces. As against this may be set the close co-operation and help that the provincial health administration will have to provide in order to enable the institution to function properly, particularly from the point of view of facilities for field training and research. In these circumstances it is recommended that the Central Government should bear 50 per cent. of the cost, non-recurring and recurring, and that the remaining 50 per cent. be distributed equally among the provinces. It is anticipated that it is during the short-term programme of rapid expansion of our health organisation that the need for financial help from the Centre to the Provinces will be the greatest. It is therefore suggested that, at the end of the first ten years, the question of redistributing the burden of expenditure may be taken up and that a reapportionment of cost may be made.

It is desirable that the administration of these institutions, including the appointment and control of the staff, should be vested in the Central Government. In the case of institutions under this category with no previous history of administration by the provincial authority, there seems to be no special reason for transferring control to that authority. However, certain suggestions will be made later to ensure co-operation between the institutions and the provincial authorities concerned.

30. (ii) Institutions under category (2) form a class apart from those already discussed. There will be organisations already in existence and financed and controlled by the Provincial Government concerned. An improvement and expansion of their activities are being suggested in order to enable them to provide training facilities of the requisite standard for the country as a whole. In these circumstances it seems reasonable to suggest that, so far as recurring expenditure is concerned, the Province need contribute only the average annual amount it had been spending for the past three years. Of the additional expenditure that will be required for the maintenance of the institution, it is suggested that the Centre may

contribute 50 per cent. and that the Provinces, excepting the one in which the institution is situated, may share equally the remaining 50 per cent. As regards capital cost the Centre may contribute 50 per cent. and in the distribution of the remaining 50 per cent., the Province in which the institution is situated should also bear an equal share with each of the other provinces.

These proposals should be subject to revision at the end of the first ten years.

As regards administrative control, it seems reasonable to suggest that the Provincial Government, which had so long been in charge and had, on its own initiative, developed the existing facilities, should continue to be in charge.

81. We have already pointed out the need for the closest possible co-operation between the Provincial Health Department and the post-graduate training centres under both categories, if the latter are to function properly. Some provinces may contain two or three or more such centres of training. We therefore suggest the establishment of a small Committee with the Provincial Director of Health Service as the Chairman and with the Directors of the Institutes in the province and the three Provincial Deputy Directors in charge of Professional Education and Research, of Medical Relief and of Public Health as members. All local difficulties in respect of individual institutes can be quickly resolved through the consultations that such a Committee will provide, while the Central Committee for Post-graduate Education will probably find that the Provincial Committee can be of great value in helping to raise the standards of training in these institutions.

#### **The composition of the Central Committee for Postgraduate Medical Education**

82. It is suggested that the composition of the Committee may be as shown below:—

The Director-General, Health Services (Chairman) or, in his absence, his Deputy who deals with professional education and research.	1
A representative from the Medical Faculty of each of three Universities in British India in rotation	3
Two representatives of the Scientific Advisory Board for Medical Research, which has been recommended elsewhere in the report for the organisation and control of medical research in India	2
It is desirable that one of them should be a distinguished scientist who is not a medical man.	
Two representatives of the Medical Council of India	2
Five Provincial Directors of Health Services, or in their absence their Deputies in charge of professional education and research, in rotation	5
Two representatives for all the postgraduate training institutions under category (1) described in this chapter	2
Two representatives for all the postgraduate provincial centres under category (2) described in this chapter	2
Two Directors of Provincial Research Institutes	2

The Committee should have a full-time Secretary.

The Committee will have a strength of 19 members, including the Chairman. It is suggested that the tenure of office, except in the case of those who hold their seat in their official capacity, may be fixed at three years.

33. The creation of an Executive Committee consisting of about five to seven members, the Chairman of the main Committee being also the Chairman of the Executive Committee, is recommended. It is also suggested that the main Committee should divide itself into Advisory Committees for dealing with different subjects with power to co-opt outsiders as members when discussing particular problems.

34. *Recruitment and control of the staff of the institutions under categories (1) and (2).*—We have already recommended that institutions under category (1) should be under the control of the Central Government and those under category (2) under the control of the Governments of the provinces in which they are situated. The general principles, which should guide recruitment in both cases, are in our view the same. We therefore make the following recommendations, which are based on the procedure we suggested in the chapter dealing with the organisation and inter-relationships of the central, provincial and local health administrations (Chapter XVII):—

- (1) Recruitment to these posts should be solely on considerations of merit.
- (2) The venue of recruitment should be India and recruitment should be made through the Federal Public Service Commission or Provincial Public Service Commission as the case may be.
- (3) It is essential that the best persons available should be secured. In respect of individual posts a search should be made through the country in order to investigate the possibility of securing suitable persons of the required calibre. It is only when this is not found to be possible that recruitment through the world market should be resorted to. The experts who are obtained from abroad should be entertained on short-term contracts, normally extending from three to five years.
- (4) The condition should be laid down in every case that, within the period of the contract, a suitable Indian should be trained for taking on the duties at the end of the term.
- (5) The selection of suitable persons from the world market should also be done by the Federal Public Service Commission or the Provincial Public Service Commission as the case may be, with the aid of such *ad hoc* committees as may be formed in the respective countries in order to assist the Commission.
- (6) There should be no reservation of any of the posts for the members of any services. The sole criterion of selection should be merit and reservation of posts is incompatible with this principle.

35. *Salaries.*—We have already discussed the question of salaries in the chapter referred to above. Here again we adhere to the principles we enunciated.

As regards persons recruited from abroad, the salaries offered will have to be such as will be necessary to secure the class of persons required. They will, of course, fall outside the regular medical services of the country and, as has already been pointed out, should be regulated by short-term contracts.

For Indians the problem of recommending suitable scales of pay is by no means easy. We have discussed the different aspects of the

problem in that chapter and do not propose to traverse the same ground again. We have suggested the appointment of an *ad hoc* committee by the Government of India for an examination of this complex and important problem, in order that suitable recommendations may be made available to the Central and Provincial Governments on which they can base reasonable scales of salary for the different categories of their employees.

36. *Legislation.*—The proposals made in this chapter for the organisation of postgraduate education in the country raise certain points of departure from existing administrative procedure and require, for the successful functioning of the institutions that will be set up, close collaboration between the Central and Provincial Governments. It seems essential therefore that legislative sanction should be secured for the implementation of these proposals in order to ensure that the necessary adjustments between the Centre and the Provinces may be placed on a legal basis. But such adjustments between the Government of India and Provincial Governments are required in many spheres in connection with the development of the national health programme. We have recommended elsewhere the enactment of comprehensive legislation in order to secure these objects. In our view any legislation that may be necessary in respect of the proposals embodied here may well form part of such comprehensive legislation and need not be taken up separately.

#### **Refresher Courses for General Practitioners**

37. One of the most serious handicaps in the raising of the general standard of medical practice in this country is the absence of any provision for refresher courses. New ideas and new discoveries in medicine come forward with such bewildering rapidity that it is hardly possible for the busy doctor to keep abreast even of those advances in knowledge which are necessary for him in the daily carrying on of his profession. This fact is fully realised in all the more advanced countries and provision is made for both long courses and short compressed courses on a great variety of subjects of medical interest, given by leading experts in large centres which practitioners may arrange to attend. Arrangements are also frequently made for touring units to take the courses to the doctors in the more outlying districts.

38. Opportunities for such courses, at least once in five years, should be available in India for all medical practitioners, including private practitioners as well as the doctors in public service. Our programme of health development will tend, as it proceeds, to absorb large numbers of existing general practitioners as well as almost all the new medical men who will be produced for many years to come. Therefore the members of the State health services will, as the years go by, be increasingly benefited by the proposed refresher courses. The kind of periodical training required by private practitioners and by large numbers of medical officers in public service need not, however, differ because both classes of medical men will be dealing in general practice in the community and not with any specialised form of medical service. In the interests of those who are in public service the refresher courses will lay emphasis on the preventive aspect of medical practice and we feel that such emphasis will be for the benefit of private practitioners also.

39. The whole aim of such refresher courses should be (a) a brushing up of the knowledge which every general practitioner should possess. This should include a revision of the aetiology, diagnosis

and treatment of those diseases with which he is in daily contact; (b) an account of recent important advances in diagnosis, prognosis and treatment, with particular emphasis on methods which can be applied by the practitioner himself and (c) an exposition of the recent advances in the diagnosis and treatment of diseases with which the general practitioner should be familiar, though he may not always be able to apply them himself.

40. The emphasis in these courses should always be on the practical aspects of the training and the lectures should be 'predominantly' clinical lecture demonstrations. In fact the whole success of the refresher courses will depend on the extent to which set lectures and theoretical disquisitions are relegated to the background. The conveniences of the general practitioner, the amount of time that he can spend, the facilities that are to be placed at his disposal and those available for him at the training centres should all be borne in mind.

41. *Nature of refresher courses.*—There are several lines along which refresher courses may be arranged.

(i) Whole-time refresher courses which may extend from two weeks to two months. It is desirable to encourage short-term courses of two to four weeks, as many medical men may not find it practicable to be away from their duties for longer periods.

(ii) Part-time courses which may be

- |                       |  |
|-----------------------|--|
| (a) week-end courses  | } spread over weeks or months organised on a systematic basis. |
| (b) whole-day courses |  |
| (c) half-day courses  |  |

(iii) One educational session once a week or fortnight conducted throughout the year.

(iv) Short-term posts in a recognised hospital for periods ranging from one month to three months.

42. *Place or institution for refresher courses.*—We recommend that facilities for refresher courses should be developed in all hospitals attached to secondary centres, district headquarters, medical colleges and the headquarters of each province. Such a wide distribution of provision for these courses is suggested in order to make it possible for medical officers in the State health services and for private practitioners to obtain the training at periodical intervals. In the case of doctors in service these refresher courses will be considered as duty while in the case of practitioners, it is desirable that, in order to encourage them to take the training, they should be exempted from payment of fees and, if they have to leave the place of work, that they should be given a subsistence allowance during the period of training, if they ask for it.

It will be seen that the agency responsible for the development of facilities for refresher courses will be Provincial Governments. Even so, it is suggested that, in university centres, the organisation of such courses should be undertaken in consultation with the universities concerned.

**The Provision of Special Training in Certain Branches which are so important as to warrant separate consideration**

43. *Tuberculosis.*—There can be no question that this disease still remains as one of the "Captains of the Men of Death" in India, and special attention must be given to the training of the personnel necessary to combat it. It is obvious that the mere provision of the hospitals and sanatoria etc., which have already been recommended

will be of no avail unless a very considerable technical staff is simultaneously prepared. The training of this staff divides itself naturally under three heads.

(a) *Undergraduate training.*—The need for special instruction in tuberculosis is referred to in our memorandum where a three months' course of out-patient attendance and clinical demonstrations in the wards is recommended. The lectures and demonstrations should form part of the general teaching of medicine, and we are definitely of opinion that in this subject clinical demonstrations are of greater value than didactic lectures.

(b) *Refresher courses for the general practitioner.*—A four weeks course similar to that outlined by the Tuberculosis Association of India is recommended. It should be given in the chief provincial centres in co-operation with the teachers of general medicine and the special tuberculosis hospitals in the province.

(c) *Postgraduate training in tuberculosis.*—It is desirable that graduates of suitable aptitude should be encouraged to take up postgraduate training in tuberculosis. Such postgraduate training should be taken only after the completion of the internship for one year which every person will be required to undergo after passing the qualifying examination for the medical degree.

44. Postgraduate training in tuberculosis should cover a period of one academic year and the following facilities should be available.

(i) A central clinic with a staff having recognised training experience and with proper equipment for X-ray and laboratory diagnosis, in order to enable it to carry out a full programme of diagnostic and preventive work including contact examination, follow up, and after-care work. There should be a minimum attendance of 1,000 new cases requiring diagnosis in a year.

(ii) A sanatorium or hospital for pulmonary tuberculosis of at least 150 beds where all modern methods of diagnosis and treatment are carried out and where a minimum of 50 thoracoplasties are done in a year. The teaching staff should have had special training and adequate experience.

(iii) Facilities for study of the diagnosis and treatment of non-pulmonary tuberculosis—For this purpose, the orthopedic department of the general hospitals attached to the university medical training centres may be fully utilised.

(iv) Teaching in pathology, bacteriology, etc. associated with tuberculosis in a department attached to a medical training centre except in those rare cases where a specialised tuberculosis institution furnishes all the available material and has a special department of pathology and bacteriology attached to it.

We recommend that, if these conditions can be fulfilled, trainees should be eligible for a special Diploma in Tuberculosis which should be instituted by the various universities.

45. In addition to the training of medical men as specialists in tuberculosis there is a great need for the training of health visitors having a special knowledge of this disease. It is true that, when the evolution of the public health nurse reaches the practical stage, such nurses will include such knowledge as part of their general equipment and this may best be arranged for them by a course of four months

at a tuberculosis clinic and two months at an in-patient tuberculosis institution.

46. In view, however, of the difficulty of securing personnel for sometime to come, we recommend that, as a short-term policy, special tuberculosis health visitors should be trained, both male and female, who should possess the school leaving certificate as a basic qualification and should have special training in a recognised centre for a period of at least 12 months, nine months of which should be spent in tuberculosis clinics and three months in an up-to-date tuberculosis institution. In due course, when sufficient trained nurses become available, this interim method of training may be discontinued.

47. A brief reference may be made to the training centres that we have recommended, elsewhere in this report, to be established during the short-term programme. The number of places, in which the facilities indicated by us in an earlier paragraph as being essential for such centres can be made available without delay, are only five. During the first five years of the programme these will be supplemented by seven more training centres. During the same period we have recommended the creation of 33 tuberculosis hospitals with provision for 200 beds in each and of a well-equipped and adequately staffed clinic in association with each hospital. These institutions will become additional training centres both for doctors and for nurses (or health visitors) during the second five years. Thus forty five such centres will be working throughout the period. Our scheme of expansion provides for the establishment of another set of 33 hospitals and associated clinics during the second five years and, of these, it may well be that about 20 will function during the last two years of the period.

48. *Mental Hygiene.*—This subject must become of even greater importance than it is at present in any advanced scheme of preventive medicine. The increasing strain of modern life playing upon an organism which is often inadequate for meeting it must lead to an increase of the number of cases on the borderline of insanity, and also of those actually under care in mental institutions. There has been up till now a neglect in this country, of the advances made in psychological medicine, but any scheme for the future must allow for the training of an extensive staff of clinical psychologists, psychiatrists, social workers and allied personnel.

49. We have drawn attention in our memorandum to the need for undergraduate training in this branch of medical knowledge, both in early and later periods of the course. In addition to such undergraduate training we suggest that postgraduate training in psychiatry should be established at universities in suitable institutions, such training leading to the granting of a Diploma in Psychiatric Medicine.

50. Refresher courses in mental hygiene and psychiatry for the general practitioner and the medical and surgical staff of general hospitals would be useful. Psychiatric units or departments should be established in general hospitals to facilitate both undergraduate and postgraduate teaching, though to open these too early before trained personnel become available to conduct them would be bad propaganda. In the United Kingdom modern developments in mental health services are doing much to lessen fears and prejudices among the public. It is vital that, in any future organisation of medicine,



psychiatry should not remain segregated and that it should take its place in the general scheme, subject to the provision of adequate and well trained personnel.

51. In order to make adequate trained personnel available for teaching purposes we may make two recommendations. One is that specialists should be obtained, on short-term contracts, from abroad to take charge of mental hospitals and to organise teaching programmes and social services during the early stages of development. The second is that selected graduates should be sent out to the United Kingdom or the United States of America for postgraduate training in psychological medicine, after holding a resident appointment for about six months in a mental hospital in India, if the candidates have not already had that experience.

52. *Dietetics*.—The subject of dietetics has been badly neglected in all hospitals in India and even in teaching centres and little emphasis has been placed upon this aspect of treatment. Not only have dieticians to be trained who will be in a position to rationalise the system of dieting in public institutions but the teachers themselves have to be trained in this subject, initially, with special reference to the needs of this country. We understand that a step in this direction is being taken by the Central Government in connection with its scheme for the award of scholarships for overseas training in different subjects. We consider that a Department of Dietetics should be established in all teaching centres and that properly trained dieticians should be available at such centres both for organising departments of dietetics and for carrying on research and the training of dieticians, who should then be employed in hospitals, public institutions, hostels, schools etc.

53. In this connection it may be mentioned that, for the past seven or eight years, under the auspices of the Indian Research Fund Association, training courses in nutrition have been carried out in the Nutrition Research Laboratories maintained by that Association in Coonoor and that well over a hundred workers, who belong mainly to the Health Departments of the different provinces and of certain Indian States, have been trained during this period.

#### **The Establishment of Courses designed to raise the Existing Licentiate to the level of the "basic doctor"**

54. If our recommendation as regards the conversion of schools into colleges is accepted, after some time, there will be no further additions to the ranks of the licentiates. The question, however, of affording to existing licentiates facilities for postgraduate training presents itself and deserves serious consideration. There are two types of such postgraduate training that may be given, (1) training which will enable them to obtain a university degree and (2) advanced training in the different specialities.

(1) *Courses leading to degree qualification*.—There are a large number of licentiates, particularly those under 40, who are anxious to obtain a university degree. The All-India Medical Council has suggested certain changes which some universities have accepted, the result of which will be that a licentiate can within 18 to 24 months obtain the Degree of M.B.B.S. Special concessions to those who are serving in the armed forces so that they may, after demobilisation, proceed to a degree have also been recommended. We consider that

every encouragement should be given to all licentiates who wish to obtain the full medical qualification and they should be given every reasonable facility in the different medical colleges to pursue the necessary courses of study. So far only a few universities have seen their way to arrange this, but we suggest that it should be the endeavour of every university and every medical college to reserve a much larger number of places for licentiates so as to enlarge substantially their opportunities to obtain a medical degree.

(2) *Advanced training for licentiates.*—It is desirable that licentiates should have opportunities of training so that they may be in a better position to practise the various specialities. There are at present only a few centres where such training can be obtained by licentiates. The Calcutta School of Tropical Medicine and the All-India Institute of Hygiene and Public Health afford opportunities for licentiates to acquire their diplomas while the Madras Government have introduced special courses in ophthalmology, obstetrics and gynaecology, tuberculosis and clinical laboratory sciences for licentiates leading to a Government diploma after a period of training for one year. We feel that such diplomas should be made more freely available to licentiates on the lines which we have suggested in our proposals for the postgraduate training of university graduates.

55. Three of us (Drs. Amesur and Narayanrao and Pandit Maitra) are of opinion that medical licentiates should be permitted to obtain postgraduate degrees and diplomas granted by the universities without completing the degree course. They state "There is a very large number of licentiates in the country who are specialists in different branches of medicine and we feel that they should have unfettered chances to take up and compete for university postgraduate degrees and diplomas in their specialities without undergoing the complete university M.B.B.S. course."

## (II) DENTAL EDUCATION

56. The provision of an adequate service for the dental care of the population is now recognised in all countries as an essential part of any comprehensive scheme for public health and medical relief. Unfortunately, in India, this matter has, up to the present, received so little attention from universities or from the State that there are only four institutions available for the training of dentists—two in Bombay, one in Calcutta and the fourth in Lahore. One of the two in Bombay and the dental college in Lahore are supported by the respective Provincial Governments and the other two are under private management.

57. Of those dental surgeons who practise in India, the vast majority treat only the wealthy. For the poor there is practically no provision at all, and throughout the country dentists are employed only to a very limited extent in the hospitals under State control.

58. In the West, a basic minimum of 1 dentist to 3,000 population is not considered to be sufficient, but, as the incidence of dental caries in India is relatively less, it would probably be permissible for us to work on a basis of 1 dentist to 5,000 population. This arrangement would require about 75,000 qualified dentists in thirty to thirty-five years, on the assumption that the population of British India will be about 375 millions by that time. This would necessitate the training

of at least 2,500 per year over that period and the establishment of 25 Dental Colleges, each capable of admitting 100 students per year.

59. A similar difficulty was experienced in New Zealand and was partly met by the training of "dental nurses" for a period of two years with matriculation as the basic minimum qualification for entrance. These 'nurses' were capable of carrying out the simpler operative procedures which take up so much of the average dental surgeon's time, but require no very high technical skill. There is little doubt that, in India, a sufficiently large body of matriculates, both men and women, could be induced to take up this interesting and worth-while work. They could, when qualified, staff the school dental clinics and assist in hospitals and dispensaries, in all cases under the supervision of a fully-qualified dentist. The proposed title for such personnel is "dental hygienists". They would have to be trained at government expense, in the first instance, and required to enter into a bond to work for 5-10 years.

#### **Planning for the expansion of Dental Education.**

60. In planning for the expansion of dental education in India there are two initial difficulties:—

- (1) the extreme shortage of adequately trained Dental Surgeons available—only 1 to 400,000 of the population and
- (2) the difficulty of obtaining teachers of the right calibre to staff new colleges on a large scale.

61. Provision will have to be made for the training of three types of personnel:

- (1) the dental surgeon;
- (2) the dental hygienist;
- (3) the dental mechanic.

62. The responsibility for the training of the Dental Surgeon will of necessity be shared between the Medical and Dental Colleges. The training of the other two classes (dental hygienists and dental mechanics) will throw no additional burden on the Medical Colleges but will be undertaken entirely by the Dental Colleges. Provided all senior posts are made full-time, the professors of the Colleges can easily arrange for all lecture courses for the hygienists and no separate training institutions will be required. There are in India very few properly trained dental mechanics and large numbers will be required to meet the growing demands of the profession in colleges, hospital service, and in private practice. In a State Dental Service it would be wasteful economically if the higher paid dental surgeon were required to devote a large proportion of his time to laboratory work. Given sufficient accommodation and adequate staff, the dental mechanic could also be trained in the Dental Colleges under the Professor of Prosthetic Dentistry, and for this purpose an intensive course in mechanics is suggested.

#### **Dental Colleges**

63. All dental colleges should be directly affiliated to a University in order to regularise the conferment of a Dental Degree at the conclusion of the course of study, and a separate Faculty of Dentistry should in each case be created, together with a Board of Studies. The minimum entrance requirements should be the same as those

for a Degree in Medicine; the course should extend over a period of four years, and lead to the degree of B. D. S. (Bachelor of Dental Surgery). The courses of study and the regulations for the Degree together with the syllabus should follow the general lines laid down in Appendix 81.

64. A separate course of two years' duration may be given for those medical graduates who wish to qualify for an additional Degree in Dentistry.

### **Postgraduate Instruction**

65. Appointments as "house surgeons" should be instituted in all Dental Hospitals run in conjunction with Dental Colleges, so that additional training on a salaried basis may be available for graduates. Stipends for such appointments should be on the same scale as those given to medical house surgeons. In view of the present acute shortage of teachers, all graduates in Dentistry should be encouraged to proceed to a higher degree, and provision for this should be made in all universities by the establishment of the degree of M. D. S. (Master of Dental Surgery). In that way only can a well-trained body of teachers of Dentistry be gradually built up in India.

66. As a temporary measure dental graduates should be encouraged to proceed overseas to study the modern trends of dental education and to pursue courses of training in special subjects in order to qualify for professorial appointments on their return to India. At the same time, during the whole short-term period, it may be necessary to engage dental professors from outside India to supplement the staff of the new colleges, and they would have to concentrate very largely on the post-graduate training of prospective teachers.

### **Training Centres**

67. In view of the difficulty in obtaining well-trained dental teachers for the short-term programme of 10 years it is advisable that the number of dental colleges proposed to be opened in India during that period should be limited. For effective distribution of facilities it is suggested that dental colleges should be opened at Calcutta, Bombay, Madras, Lucknow and Patna, and that the dental college at Lahore should be expanded. Both from the point of view of economy and efficiency it is desirable that each dental college for undergraduate students should be associated with a medical college, which should be extended so as to include a wing for the dental college. There should be the closest co-operation between the staffs of both these colleges in arranging for courses of study, and the teachers of the medical college should assume responsibility for the instruction of dental students in those subjects which form part of the normal studies of the undergraduate in medicine.

68. Every training centre should train approximately equal numbers of dental surgeons and dental hygienists, and it is recommended that each of these centres should be capable of training 100 dental surgeons and 100 dental hygienists annually. Each training centre should normally be so constructed and equipped as to allow of those numbers being accommodated. If such arrangements are not possible, the minimum numbers should be 50 dental surgeons and 50 dental hygienists, if the proposition is to be economical for the State.

69. In short the scheme outlined above envisages, as a first step, the replacing of the private colleges in Calcutta and Bombay by Colleges affiliated to the universities, the enlargement of the college of dentistry at Lahore and the inauguration of new colleges at Lucknow, Madras and Patna with facilities in each of these six dental training centres for training 100 dental surgeons and 100 dental hygienists per annum.

### Uniformity in Dental Education

70. The establishment of some degree of uniformity throughout India is extremely desirable. It is suggested that ultimately, through an all-India body, the courses of instruction etc. which are to be pursued at all dental colleges should be standardized. Such standardization through a central body could be ensured by:—

- (a) a uniform standard of entrance with Intermediate Science (Medical Group) as the minimum;
- (b) a four year dental course;
- (c) affiliation of every dental college to a university, preferably with the creation of a separate Dental Faculty, but, in any case in close liaison with a Medical College;
- (d) uniformity in curriculum standards, technical and clinical requirements, and standards of examination;
- (e) a reasonably low level of tuition fees and
- (f) supervision over all dental institutions to see that they maintain the standards of efficiency which are laid down for them.

We have recommended in Chapter XXII the creation of an All-India Dental Council and also of Provincial Councils.

### Dental Legislation

71. Instead of each Province having its own Dental Act, comprehensive all-India legislation should be introduced, which should, in addition, ensure complete reciprocity between the different provinces. Dentistry as a science can make little real progress in this country until it is upheld by suitable legislation directed to compulsory registration, and the prohibition of practice by unregistered persons. One of us (Mr. N. M. Joshi) is, however, of the view that such legislation is premature, but if passed it should not be made applicable to those areas where the free services of a registered dentist are not made available within a reasonable distance from the residence of a patient. The following advantages will accrue from registration—

- (1) the standard of the profession in India will be raised,
- (2) the public will be protected against practice by unqualified and unskilled persons,
- (3) it will be ensured that persons trained under the scheme as dental hygienists and dental mechanics will keep within their proper sphere of activity,
- (4) trained dental surgeons will be kept aware of the need to adhere to the standards of professional etiquette which are expected of them.

Registration must be separate for the three categories of dental surgeons, dental hygienists and dental mechanics.

### Post-war Dental Services.

72. Though we have referred to the subject of dental service in our chapter on the short-term programme, it may be noted here that the object of the proposed expansion of dental education is not only to provide private practitioners, but also to furnish the personnel for Provincial Dental Services which will cater for that huge proportion of the population, which is at present completely neglected. Our short-term dental programme will attempt to provide:

- (1) dental sections at all the secondary health unit hospitals that will be established during the short-term and
- (2) a travelling dental organisation for the area covered by each secondary unit.

73. It is our opinion that the increase in the number of dental colleges and improvements in the training of dental surgeons and hygienists will not lead to satisfactory results unless the State itself undertakes the establishment of a comprehensive dental service to meet the urgent needs of the population. The above proposals for the short-term constitute the beginnings of such a comprehensive service.

### (III) PHARMACEUTICAL EDUCATION

74. The present standard of training for those engaged in the practice of pharmacy is entirely inadequate and a drastic revision of the education system in this subject is essential.

We consider it necessary to provide educational facilities for three classes of persons.

- (1) The licentiate pharmacist
- (2) The graduate pharmacist.
- (3) The pharmaceutical technologist.

75. The licentiate course will provide for the large number engaged in dispensary work in chemists' shops, dispensaries and hospitals. The initial standard should be the matriculation or an equivalent examination with physics and chemistry as compulsory subjects of study. A two-year course at an approved educational institution is necessary, and the following subjects should be included in the syllabus of study: Chemistry, Biology with special emphasis on Botany, Elementary Physics, Pharmacy, Pharmacognosy, Elementary Pharmaceutical Chemistry, Elementary Physiology and Forensic Pharmacy (Appendix 32). There should be two examinations held, one at the end of the first year and the other at the end of the course. The standard of the examination should be controlled by an All-India Pharmaceutical Council which, it is hoped, will be established for the whole of India, and which will maintain a uniform standard throughout the country. After passing the examination, the apprenticeship should continue before an individual is considered qualified as a pharmacist. The title of pharmacist should be conferred on persons who hold this diploma.

76. The course for a graduate pharmacist will be designed to train the smaller number who will be engaged in manufacturing concerns,

analytical laboratories and educational medical institutions. It will be a degree course for either the B.Sc. (Pharmacy), or the B. Pharmacy at the discretion of the University concerned. The entrance qualification for this course should be the Intermediate Science with Physics, Chemistry and Botany as a compulsory course of study or its nearest equivalent. The duration of the course should be for three years and should include Inorganic, Organic and Physical Chemistry, Botany, Biology, Elementary Physiology, Pharmacology, Pharmacy, Pharmacognosy, Pharmaceutical Chemistry and Forensic Pharmacy. Holders of the above Degrée should be eligible for the pharmacist's diploma without further examination, provided they undergo an apprenticeship for one year.

77. For those desiring to take up the manufacture of pharmaceuticals and drugs on a commercial scale it is recommended that there should be, in addition to the graduate course in pharmacy, an additional course of one year in chemical technology, design, equipment etc.

This degree should be open to those who take up technological studies after qualifying for the B. Sc. Degree with Chemistry as the main subject, or to those who possess the Degree of B. Sc. with Pharmacy. The period of training should range from one year to eighteen months and the special object of the training should be to enable such persons to undertake the manufacture of pharmaceuticals and drugs and to control institutions where the large-scale manufacture of pharmaceutical preparations and the standardization of such preparations are undertaken.

78. The number of institutions in which proper training for licentiates can be given should be determined by the Provinces concerned, taking into consideration the requirements of the Province and the extent to which facilities are available in the proposed training centres. A district headquarters hospital should be in a position to train licentiates, provided proper staff and adequate equipment are available.

79. The training for the degree course in pharmacy should be undertaken by the Medical Colleges affiliated to Universities, and for this purpose, their Departments of Pharmacology and Therapeutics should be sufficiently enlarged for adequate courses of training to be given. The technological course should be arranged in Technological Colleges affiliated to the University.

80. A detailed syllabus for the diploma course in pharmacy suggested by Dr. B. Mukerjee, Director, Biochemical Standardisation Laboratory, Calcutta, is given as Appendix 82.

It is proposed that, as soon as licentiates under this scheme are available in sufficient numbers, the training of compounders may be done away with.

#### (IV) THE EDUCATION OF PUBLIC HEALTH PERSONNEL

##### Introduction

81. Scientific instruction in hygiene may be said to date from 1868 when the brilliant chemist and physiologist Max Von Pettenkofer was elected to the newly created chair in that subject at Munich, and there founded the first University Institute of Hygiene. The

English D. P. H. was instituted in 1886 with the dawn of bacteriology and preventive medicine, while the first University School of Hygiene in the United States of America was established at Johns Hopkins in 1919.

82. No branch of medical education is in such a state of flux as that which concerns the training of workers in the field of public health. This will be evident from a study of the report on European Institutes and Schools of Hygiene issued in 1938 by the League of Nations, from which it appears that, at that time, there were four types of schools engaged in giving instruction in public health:

(a) University institutions organised for public health teaching and research work. At present there is only one example in Europe—the London School of Hygiene and Tropical Medicine. This is an academic institution with all the duties and privileges of a University School.

(b) University Institutes of Hygiene which have combined with the regional Institutes of Hygiene to form a single unit, supported in their work by both the Education and Health authorities. The Professors of Hygiene are at the same time Directors of the Regional Institutes. Instruction in hygiene is given to medical students as well as postgraduate training. Such institutes are found at Nancy, Jassy and Bucharest.

(c) Institutes of Hygiene which organise public health courses by means of a department known as the School of Public Health, in which the staff of the Institute provides the greater part of the instruction. Such institutes are found at Warsaw, Budapest, Rome and Ankara.

(d) Schools of Hygiene as special institutions of the State Health Administration at Zagreb and Athens. These schools, in addition to giving courses in public health, carry out part of the programme of the State Health Service, Zagreb in the matter of health education, surveys and sanitary engineering, and Athens in anti-malaria work and sanitation.

The postgraduate training carried out by these institutions is not of a uniform type, and the duration of the courses varies considerably, from six weeks at Sofia to 12 months in Athens and London. The programme also differs widely especially as regards the time given to the different subjects.

As regards the training of public health nurses, most countries have established schools and the courses are more uniform, averaging three years in length. Courses for Sanitary Inspectors vary from Warsaw 4 months to Zagreb 1 year.

The primary aim of the institutions is not only to train doctors in public health, social insurance, and social assistance, but also to carry out pure and applied research. Only in England, France, Hungary and Greece is a diploma or certificate in Public Health compulsory for applicants for public health posts.

Another type of instruction exists in Russia where there are no Schools or Institutes of Hygiene in the accepted sense, but where Hygiene forms one of the three faculties which provide training for a medical degree in each medical school.



83. We have, in other chapters of this section, adverted to the extreme importance of presenting the principles of preventive and social medicine to students of medicine, nursing and other branches of health activity during their period of training. We have recommended the setting up in medical colleges of adequately staffed and equipped departments of preventive and social medicine as centres of teaching and research. We have also suggested the provision of rural and urban health organisations in association with these departments, in order that these centres may provide facilities for field work to students and for the investigation of community health problems to the different departments of the college. We have expanded our proposals regarding the education of nurses so as to include the training of the public health nurse.

84. The postgraduate training now provided through the course for the diploma in public health will, we believe, be largely incorporated in future in the course of training for the undergraduate, in view of the growing demand for doctors trained equally in preventive and curative health work. Postgraduate training in preventive and social medicine will then have, as its objective, the provision of facilities for advanced training in such branches of the subject as malariology, maternity and child welfare, industrial hygiene, public health administration, epidemiology, public health laboratory practice and statistics. Such specialised training may be of two types. The first will be of a limited character and will have as its purpose the equipment of health workers with a reasonable measure of proficiency in these subjects. This course of instruction may, it is suggested, ordinarily range from about three months to one year. The second will be for those who desire to attain the status of specialists in each of the abovementioned branches of preventive health work. For them we suggest that the period of training should be about three to five years. The candidate should be attached to the preventive and social medicine department of a medical college and, during this period, he should associate himself more and more with the teaching, research and administrative activities of the department, including participation in the field training given to the students. We anticipate that such specialisation will generally be undertaken after an individual has had some period of practical experience in preventive and remedial health work. From the persons so trained it is suggested that recruitment can be made of suitable individuals for the more responsible administrative posts in the health department as well as for the higher teaching posts in the departments of preventive and social medicine in medical colleges.

85. In view of the possible developments suggested above we believe that training in preventive and social medicine is likely to be developed in two types of institutions, (1) in the departments of social and preventive medicine associated with medical colleges and (2) in special institutions on the lines of the All-India Institute of Hygiene and Public Health, Calcutta, or the London School of Hygiene and Tropical Medicine. This second type of institution will probably devote itself solely to postgraduate work and to research into community health problems. It will also require the provision of field training centres to work in association with it.

86. There remains for discussion in this chapter the question of training three types of workers whose activities are solely related to

the problems of preventive medicine. We refer to the Public Health Engineer, the Public Health or Sanitary Inspector, and the Public Health Laboratory Worker and Technician.

#### **A. The Public Health Engineer**

87. Our proposals for postwar health development require a large number of qualified public health engineers for the tackling of the problems of environmental hygiene. Public health engineering applies knowledge concerning the practical control and modification of the human environment to the prevention of disease and the promotion and maintenance of health. The major activities of a public health engineer include the following:—

1. Quantitative and qualitative control of water supplies.
2. Removal of solid and liquid community wastes.
3. Control of milk and food right from production through transport to distribution.
4. Control of air pollution.
5. Control of thermal environment in housing, industry, etc.
6. Control of pollution of streams, rivers, harbours, waterways, etc.
7. Control of animal, insect and bacterial agents of communicable diseases.
8. Safety and control of special occupational hazards in industry.
9. Control of light, noise, etc.
10. Promotion of amenities such as parks, playgrounds, bathing places, etc., slum clearance, town planning, general cleanliness and control of offensive trades.

88. Other activities are continually being added to this list and it is evident that such specialised work calls for engineers with a definite public health outlook and a broad general education. A reference to the survey section of our report will show how backward is the control of sanitation in this country. In order to make a definite improvement in existing conditions it is estimated that about 2000 adequately trained engineers will be required, with a yearly allowance of 80-100 for replacements.

89. As regards the type of training required, we trust that the enumeration of the public health engineer's functions made above will remove any impression that may exist that a course of instruction in Applied Hydraulics given to a student of Civil Engineering is sufficient to provide the type of worker who can satisfactorily perform the important duties expected of him.

90. A beginning in training can be made at the All-India Institute of Hygiene at Calcutta in collaboration with the Bengal Engineering College and the Calcutta University. Arrangements should be made to provide for at least 50 students at first on an all-India basis. For the first ten years 80 per cent. of the admissions should be restricted to specially selected engineers between the ages of 25 and 40 who are already employed in the Provinces and States.

91. The course should consist of academic instruction and demonstrations for eight months with an examination followed by six months' practical training at selected centres. Those who are not

already in the service should undergo practical training for one year. Candidates may be awarded a degree or diploma on the completion of the course.

92. A syllabus for a special course for qualified engineers to become public health engineers and more elementary courses in public health engineering (1) for incorporation in the training course of all engineering students qualifying for a degree in Engineering and (2) for Engineering Supervisors to be employed in small municipalities are given in Appendices 33, 34 and 35. These were prepared for us by Professor Subrahmanyam, All-India Institute of Hygiene and Public Health.

93. At a later stage it is proposed that this subject should occupy a definite place in the courses of studies provided at the different Engineering Colleges, so that instruction in public health engineering will form a part of the training of all those who qualify as engineers.

94. It is further suggested that opportunities should be given to public health engineers in public service to visit foreign countries for the study of recent advances in this subject. For this purpose the grant of four or five fellowships annually is recommended.

#### **B. The Public Health or Sanitary Inspector.**

95. The sanitary inspector is essentially a British Institution and the work of such an inspector has become more highly technical and specialised within the British Empire than anywhere else in the world. He works under the Medical Officer of Health and is, in fact, his eyes and ears, his sanitary policeman, who enforces the sanitary laws of the community. In Great Britain the certificate of the Royal Sanitary Institute and the Sanitary Inspectors Joint Examination Board is an obligatory qualification. The instruction leading to the certificate extends over six months and is given in approved technological schools. After this the candidate is required to undergo practical training for a further period of six months.

96. In India the sanitary inspector is often the only officer to look after public health and public works in many of the smaller municipalities; his duties are heavy and his professional training not adequate to meet the requirements of some of his highly technical duties. Hence he generally confines himself to supervising conservancy and spends the larger part of his time in writing reports instead of concentrating on outdoor work. The position of the inspector in rural areas is worse, for his area is so large that it is difficult for him even to complete his round of visits. He literally has no time for many of the duties which are allotted to him. In Bengal, there are at present 575 Sanitary Inspectors or one per thana of 80,000—100,000.

97. British India will require a minimum of 12,000 Public Health Inspectors at the rate of 1 per 25,000 of the population, with replacements of about 800 annually. The present number under employment is probably in the region of 3,000.

98. The training given to these inspectors must prepare them to discharge their duties efficiently, and it must not be merely academic. The present position is unsatisfactory. The minimum standard of preliminary education for an inspector should be the school final or matriculation with mathematics or science subjects. A proposed

curriculum for the course is in Appendix 36. The period of training is one year.

99. We wish to add a final observation on this subject. In order to obtain and retain the services of intelligent men for this important work it will be necessary to offer adequate rates of pay. The "apostle of health" will not carry much conviction if he is not paid enough to maintain his own health.

### C. Public Health Laboratory Workers

100. Public health laboratories have not so far undertaken the training of laboratory workers. There are many fields in which specialised training is necessary to enable such persons to staff public health laboratories at other centres. Water-analysis, examination and analysis of food-stuffs, the place of disinfectants and their protective value, problems connected with industrial health, etc., should all be taught and laboratory workers so trained will fill a definite place in any scheme of organised public health laboratory practice.

## (V) THE TRAINING OF NURSES AND MIDWIVES

### A. Nurses

101. The conditions under which nurses have hitherto been required to carry on their profession in this country are recognised by all thinking persons to be deplorable. As long as such conditions obtain it is inconceivable that Indian women from the more educated families will enter that profession in appreciable numbers. We give below in tabular form the main, but not the only, objectionable features of the present system together with the remedies proposed. It will be noted that in all cases it is within the power of Governments, if they so wish, to remove these obstacles which cause many aspiring candidates to refrain from undertaking this work which is of such prime importance to the welfare of their country:—

Present condition	Proposed remedy
1. A lack of any professional status	The granting of gazetted (civil) rank to persons who by reason of pay drawn or the position of responsibility they occupy may reasonably be given such rank.
2. Underpaid senior positions	Salaries to be reviewed and increased so as to render the profession attractive and to meet local economic requirements.
3. Grossly understaffed hospitals with consequent overwork.	An attempt to reach in due course the international standard of one nurse to 2½ beds.
4. Deplorable living conditions with gross overcrowding.	A fresh and vigorous approach to the problem of accommodation and diet by the authorities concerned and the provision of requisite amenities.
5. Diet not balanced and insufficient for growing young women.	
6. No recreational or cultural facilities.	
7. No general superannuation or pension schemes.	Inauguration of a pension or provident fund scheme.

### The problem examined in detail

102. There are at present the names of 9,500 nurses registered with the various Provincial Nursing Councils, but many nurses register

in more than one province, many are too old to practise, some have died and some have left the country, often without having taken their names off the registers. In our opinion a more accurate figure would be in the region of 7,000, which is equivalent to a ratio of one nurse to 48,000 of the population, or to 124 square miles of territory in British India though it must not be thought that the few nurses available are spread evenly over the country in this proportion. Many—only too many—millions of the population cannot afford the luxury of a nursing service, and many even of the State-managed hospitals are without this essential personnel. There are not in the whole of India today so many qualified nurses as there are in London alone.

103. The nurses whose names are on the various registers differ greatly in their professional ability and their educational background. There are at present approximately 190 schools where training recognised by the Nursing Councils is undertaken, but these training schools are far from satisfying even the minimum requirements of a modern training institution. In most of them students are employed as unpaid nurses, working long hours with no adequate time for study. In that way in almost every hospital in India, the education of the nurse is sacrificed to the urgent demands of the nursing service. Furthermore, in no hospital is there a staff adequate either in numbers or in experience to provide the necessary instruction and the supervision of training. An All-India Nursing Council, which we are recommending elsewhere in this report, will ensure that the required standards of training are attained by all the training institutions in the country, and that student nurses are regarded as students and not as employees of the hospitals at which they are studying.

104. (a) *The living conditions in training centres.*—The living conditions in training centres at present are, in most cases, deplorable. Overcrowding is almost universal and even the barest essentials for hygienic living are not provided. In some centres student nurses are even expected to cook their food in their own rooms in their off-duty time, while recreation rooms for nurses are practically non-existent. These conditions require the most drastic revision. Young growing women who work hard require well-ventilated rooms with sufficient regard to privacy and with special arrangements for quiet for night nurses, sufficient light and air, and an adequate diet supervised by a properly qualified person. The student nurses should be provided with accommodation of this type, free board, laundry, uniform and no charges should be levied for any of the amenities provided. Besides this they should be given a stipend ranging from Rs. 15 to Rs. 25 per mensem. The living-accommodation for student-nurses should be separate from that of staff nurses, and should include dining, sitting and bed rooms, proper bath rooms and lavatories, the apartments being fully furnished not on any expensive basis, but to meet the ordinary requirements of students. Proper facilities should be provided for recreation both indoors and outdoors.

105. (b) *The target to be aimed at.*—The target to be aimed at is the provision of one nurse to 500 of the estimated population at the

end of 30 years—roughly 500 million. This will mean an attempt to raise—

20,000 nurses at the end of	.	.	.	.	.	5 years
50,000	"	"	.	.	.	10 "
100,000	"	"	.	.	.	15 "
250,000	"	"	.	.	.	20 "
500,000	"	"	.	.	.	25 "
1,000,000	"	"	.	.	.	30 "

106. The actual number of nurses that can be trained depends upon three factors—

- (i) the number of young women with a proper educational qualification who will be prepared to enter the nursing profession;
- (ii) the number of properly equipped and properly staffed training institutions that will be available to train such nurses and
- (iii) the financial resources available for such training.

107. The great need is to elaborate a satisfactory short-term policy. The long-term programme is so intimately bound up with post-war development in other spheres, particularly education, that it must await their collateral development. There is no doubt that the spread of educational facilities, better teaching and the introduction of compulsory education up to at least the high school standard will eventually attract larger numbers to the profession. Meanwhile the immediate need is for a thorough overhaul of the existing training centres together with the establishment of others better designed and more adequately equipped.

### **Establishment of Preliminary Training Schools**

108. It must be borne in mind that not all provinces possess the same facilities for the training of nurses. In some of them the education of women has progressed further than in others. We believe that in South India, particularly in the southern districts of the Madras Presidency, in the States of Travancore and Cochin, in Mysore and the Bombay Presidency, if the conditions of service are made more attractive, a larger number of students will be attracted to the profession of nursing. As regards the rest of India the outlook is not so hopeful at present. A great handicap to the immediate setting up of regular training centres is the extreme shortage of efficient sister-tutors, and it is felt that the only immediate solution of the problem which will permit the full utilization of the very few who are at present available is the establishment of preliminary training schools at suitable centres, though it must be clearly recognised that this is an emergency short-term measure and not intended to replace the regular systematic training of nurses. It is proposed, therefore, that a sufficient number of training schools should be established over as wide an area in each province as possible.

109. These schools will give elementary instruction to students who wish to become nurses, midwives, public health nurses and hospital social workers. The basic preliminary course proposed by us for these institutions is devised to instil into the students a preventive approach to health problems from the very commencement. The nursing course can be made interesting only if it is correlated with existing educational backgrounds and linked to community and home

conditions. The elementary course is so planned that it will provide those students, who do not proceed to the full professional course, with valuable experience immediately applicable in their own homes and villages.

110. Candidates should not be less than 17 years of age and the course should not be less than 14 weeks—13 weeks for study and one week for examination. This permits of three sessions annually, allowing 10 weeks for transfers and admission of students and holidays for teaching staff. The approximate number of hours of tuition per week is 34, allowing for rest during one afternoon and a whole day in each week. (Details of the proposed course are given in Appendix 37.)

### **The Training of Nurses**

111. In order to ensure that our recommendation should be of the most practical nature we obtained the advice of a Conference of the representatives of the civil nursing profession from the provinces and of the Army nursing services of India, the United Kingdom and the United States, who have furnished us with material for the following scheme, which we now advance for training the large number of nurses who will be eventually required.

112. It is recommended that there should be two grades in the profession with corresponding types of training i.e., a junior grade and a senior grade. In addition to these two grades it is proposed that a University Degree course in nursing should be established, wherever possible, and that postgraduate courses for nurses should be instituted in order to train selected nurses for assuming the more responsible duties of their profession.

113. *The course for the junior certificate.*—The age for admission should be 17 years and the entrance qualifications should be not less than a completed course of the middle school standard. This standard of entrance may be raised as the education of women in India progresses and this course ultimately abolished as soon as there can be one uniform course of training for the nursing profession. The details of the suggested course of lectures and demonstrations for this certificate are given in Appendix 38. The length of the course should be three years.

114. *The course for the senior certificate.*—The minimum entrance qualifications for this course should be a completed course for matriculation, school leaving certificate, the Junior Cambridge or their equivalent. Training should extend over three years while, if midwifery is included, four years should be adequate to prepare a nurse to assume any responsible post in the field of general nursing or of public health. A draft syllabus for the senior certificate course is given in Appendix 39.

Though the courses arranged for the junior and the senior certificates should be entirely separate, it should be arranged in planning all syllabuses that the preventive side of medicine and the social aspects of nursing are brought continually before the student throughout her training. Instruction may be given either in English or in the chief languages of India. If instruction is given in these different languages it must be ensured that text-books are of the proper standard and that they are brought up-to-date at suitable intervals. In order that this may be ensured it will be necessary to establish a central agency or editorial board.

115. *Examinations.*—The qualifying examination for nurses should be controlled by the different Provincial Nursing Councils and Medical Examination Boards subject to the general supervision of standards by the All-India Nursing Council. There should be two examinations, an intermediate at the end of the preliminary period of twelve to eighteen months of training and a final at the completion of the course. The examinations may be held twice a year. While emphasis should undoubtedly be placed upon examinations as fit and proper tests to ascertain the progress that the nurse has made, in the assessing of educational assets greater emphasis should be laid upon the adequacy of the teaching centres, the facilities which they have at their disposal, the equipment they possess, the number of nursing staff, the hours of work for pupil nurses, the qualifications of those engaged in training, and last, but by no means least, the qualifications, attainments and personality of the head of the Nurses Training Centre.

116. *Hours of work.*—The hours of duty at present required from student nurses vary in different hospitals, ranging from 45 to 70 a week for day duty, and from 49 to 90 a week for night duty. Few schools include lecture and class room demonstrations in the duty hours, while many expect the student nurse to attend classes when off duty. It should be clearly realised that it is impossible for young growing women to carry the burdens of hard work and hard study at the same time without a danger of interference with their health. The International Council of Nurses recommends a 48 hour week both for day and for night duty and in this all classes and lectures are included. At least one hour of study should be arranged for each hour of class work and the total of classes, study and duty should not exceed 10 hours a day in a six day week. This arrangement leaves the student the necessary free time for recreation, hobbies and social contacts which are so desirable for the development of a well-balanced personality. We strongly recommend that this international standard should be the target for all training institutions for nurses in this country.

117. *Requirements of training centres.*—It is desirable that each training centre should provide training in all the subjects of the curriculum. In some cases training is given only in hospitals for women and children, while in other cases it is restricted to hospitals for men. As an interim measure we suggest that, in the former case, the training centre should have affiliated to it a hospital where both surgical and medical male patients are treated, and that nurses should be posted there for a period of at least six months. In the latter case affiliation should be sought with a hospital for women and children and training given therein for at least one year. In either case the affiliated hospital should be adequately staffed and up to the requirements of an institution for the training of medical men during internship.

118. *Qualified staff in teaching centres.*—No teaching centre for nurses can adequately fulfil its role unless it is manned by a well-qualified staff who, besides bearing the responsibility of looking after the patients, will find time for supervising, directing, and advising the student-nurses when they are on duty. It is recommended that for every 25 beds in a teaching hospital, there should be one Sister and three Staff Nurses in order to provide for supervision of the ward nursing personnel during the whole 24 hours. This excludes



the administrative staff required for night duty. In a hospital with 300 beds or less, there should be a Nursing Superintendent, an Assistant Nursing Superintendent, a Sister-Tutor, and a Home and House-keeping Sister. The administrative staff should never be less than three since it is necessary to provide for relief, off duty and for vacation. In a hospital with over 300 beds, the staff should consist of a Nursing Superintendent, a Theatre Sister, an Assistant Nursing Superintendent, a Home Sister, two Sisters-tutor, and a House-keeping Sister specially qualified with a sound knowledge of nutrition. It is our hope that eventually these recommendations will apply to all hospitals, whether teaching centres for nurses or not, but as a short-term policy we advocate that they should be considered as absolutely essential for the efficient running of a teaching hospital. There should always be a Night Supervisor who is specially qualified to carry on the administration of the hospital at night. It should not be expected that the Night Supervisor should also undertake the responsibility for emergency work in the operating theatre. Arrangements should be made for two staff nurses to be available for these night emergencies. In addition to the minimum staff suggested above supplementary provision should be made for the relief of the regular staff of the hospital during vacation and sickness.

119. *Advanced study for trained nurses.*—Such courses in hospital administration, sister-tutor courses, courses for public health supervisors and others should be instituted as early as possible. At present in most of the Provinces there are no properly qualified teachers to conduct such courses or to conduct proper courses in public health nursing. We recommend that a suitable number of carefully selected Indian ladies should be sent abroad at an early date to study in Universities, such as London and Leeds in the United Kingdom, and Toronto and Nashville Tennessee in the North American Continent, where courses of instruction are available. At least 36 scholarships should be given for this purpose every year for the next five years, and if the experiment is successful, the number of these scholarships should be increased.

120. *University education.*—Degrees in nursing are given by certain Canadian and American Universities and London University awards a Diploma in this subject. We consider it essential that such a degree course in nursing should be instituted as early as possible in India in order to provide leaders for the nursing profession from among the more highly educated and cultured ladies. It is proposed that, as a first step, the School of Nursing Administration at Delhi should be transformed into a College of Nursing. It is hoped that eventually the three provinces of Madras, Bombay and Bengal and the larger provinces will similarly develop their own Nursing Colleges. When those sent abroad for training return it is hoped that a degree course may be instituted in association with these Colleges of Nursing, so that there may be combined in one unit a Model Preliminary School, a five-year degree course and advanced courses in Hospital Nursing Administration, in the Teaching of Nurses and of Public Health Supervisors.

121. *Accommodation.*—It is emphasised that, since nearly all existing institutions are inadequately staffed, the nursing which they provide is, and must remain, of a low standard until urgent and necessary improvements have been undertaken. The main limiting

factors in this respect are accommodation and funds. If accommodation were sufficiently provided, an extra three or four thousand nurses could be trained in the existing institutions alone. It is estimated that approximately one thousand candidates are immediately available for the proposed Junior Certificate Course and a further eight hundred for the Senior.

In view of this serious hold-up in training it is urged that immediate consideration should be given to the problem of providing the required accommodation, either by the construction of new Nurses Homes, or by the commandeering of buildings suitable for this purpose. We feel that, without adequate arrangements for accommodation, the most important of our recommendations for the training of nurses cannot be carried out. In view of the obvious fact that, on demobilization, large numbers of nursing auxiliaries; both male and female, will be demanding facilities for completing their training, it is essential that these constructional works should be undertaken without delay. Priority for building materials should be given to those institutions which have made repeated and urgent requests for supplies.

122. *A Pre-nursing Course.*—In order to permeate the community with elementary notions regarding hygiene and the basic principles of nursing and mothercraft it is proposed that a pre-nursing course should be introduced in the final year curriculum of all high schools as an optional subject. Such a course would serve the double purpose of providing young women with useful knowledge wherewith to commence a nursing career, and if that is not intended, with useful experience in the management of a home and the care of children. A suggested schedule is set out in Appendix 40.

We hope that such a scheme, if given effect to, would help in providing recruits for the proposed Junior Certificate Courses at the Preliminary Training Schools. A kindred proposal, which might work to the same end by providing useful training during the period between the school leaving age and entrance to a training school, is the establishment of properly staffed centres for the day custody of the children of mothers who are at work. Such centres could have considerable scope for giving elementary instruction in hygienic principles to girls who intend to take up nursing later as a profession.

123. *The status of certificated nurses.*—In some of the more advanced countries of the world the nursing profession is recognised as being equal in status to the medical profession, in that both are concerned with the healing art although their duties and responsibilities may differ. The Matron, or the Nursing Superintendent, contributes her full share towards the administration of the hospital. She attends the weekly meetings of the House Committee, she works in close collaboration with the Superintendent of the hospital and she is regarded by the Consultant and Resident Medical staffs as their colleague. In India, however, in the opinion of the general public, the status of nurses is so low that Provincial Governments place them in the subordinate grades. The recent granting of commissioned rank to members of the Indian Military Nursing Service has done something to remove this stigma and has raised that service to the level of the Imperial and Dominion Nursing Services. We have already made our suggestions regarding the grant of gazetted status to nurses.

124. *The safeguarding of nurses against ill-health and disability: provision for old age.*—We consider it essential that nurses should be protected in sickness and in old age. The health organisation that we have recommended, if developed on the lines indicated by us, will bring within its fold a considerable proportion of the existing nurses as well as almost all those who will be trained for many years to come. In public service medical leave is one of the privileges which all enjoy while provision for old age is usually made either by the grant of a pension or through a provident fund scheme. It will be remembered that the services under local authorities will, under our health organisation, be provincialised so that the benefits under consideration will become applicable to all classes of nurses maintained out of public funds. Thus there will be adequate provision for sickness and old age in respect of the vast majority of members of the nursing profession. We recognise, at the same time, that a certain number will remain outside the public services. We have in mind such nursing services as may be maintained by voluntary organisations, including missionary bodies. We would suggest that the authorities concerned should investigate the possibility of providing the benefits under consideration to this class of nurses. The transfer of the services of a person from one Government to another does not affect such medical leave, pension or provident fund as she may have earned under the previous Government, because these benefits are also transferred to her credit in the new post. We consider that nurses serving outside the public service should also have this benefit of transference of their earned sickness leave and pension or provident fund. We suggest that the "Contributory Federated Superannuation Scheme for Nurses and Hospital Officers" introduced in Great Britain in 1928 may serve as a model for a scheme to be introduced in this country in order to afford these safeguards to this particular section of the nursing profession. One of the strongest and most important features of that scheme is that membership is continued throughout the individual's career. If contributions are suspended on migration all contributions already paid remain intact for the benefit of the member and accumulate at compound interest. In no circumstances whatever can a member lose any part of her contributions.

Although we have drawn attention here only to the need for providing such benefits to nurses in the service of private organisations, we feel that the question is one of much wider application and that other workers also require similar protection. The matter therefore deserves consideration at the hands of the authorities concerned. Such provision will appropriately form part of any general scheme of social security for the community as a whole.

Another question also seems to require consideration. Nurses are, in spite of all precautions that may be taken, continually exposing themselves to injury to their health during the normal discharge of their functions. There are also other types of health workers who are exposed to similar hazards to their health. Monetary compensation for specific damage to health caused by conditions arising out of a person's occupation is a recognised provision for industrial workers in most countries, and we feel that an extension of this benefit to workers in other fields of activity useful to the community is a reasonable proposition. Such a proposal may eventually embrace, within its scope, most persons who are gainfully employed outside

their own homes and its adoption is therefore likely to raise financial considerations of a far reaching nature. We do not consequently feel justified in doing more than throwing out the suggestion that the grant of compensation for damage to health due to causes associated with a person's occupation has a far wider field of application than that of industrial workers.

### **B. Male Nurses**

125. Owing to the social conditions and customs in certain parts of India, male nurses play an important part in the health programme of India. Men can go out to nurse in districts where women cannot go, and do work which women are unable to do. It is a regrettable fact that some excellent schools for male nurses have had to be closed because those trained in them have found it difficult to obtain posts with a salary of more than Rs. 15 to Rs. 40 a month.

126. It is obvious that, with the present acute shortage of trained nurses, male nurses and male staff nurses should be trained and employed to a considerable extent in the male wards and male out-patient departments of Government Hospitals, thus releasing women nurses for other work. The social background, professional education and entrance qualification for male nurses should be the same as for women nurses, with an equivalent salary for corresponding work. Proper living quarters for single men and family quarters for married nurses will have to be provided.

### **C. Public Health Nurses and Health Visitors**

127. There are in India today about 750 or 800 health visitors, *i.e.*, 1 to 375,000 of the population in British India. Very few of these health visitors are registered nurses. Most of them are certified midwives and have had a 9 to 18 months training in the duties of health visitors. Their work has been almost entirely limited to maternity and child welfare. None of them are rendering that type of service to the individual, family and community which is considered necessary in health programmes today. They function as maternity supervisors and train and supervise *dais* in order to provide for trained attendance on the mother at childbirth. They carry out much valuable work in their health centres and by home visiting, but the quantity of work to be done, the limited training of the health visitor and the widespread influence of superstition, ignorance and unhealthy habits, make effective health education of the public extremely difficult. In order to promote preventive work on more efficient lines it will be necessary to replace this partially trained type of health worker by the more fully qualified individual, whose functions we shall discuss presently.

128. It is regrettable that there is no uniform standard for the education and registration of health visitors in India. Four out of the eight existing schools have doctors and not health visitors in charge, and only one of these doctors has a diploma in maternity and child welfare. Only four of the schools have, under the control of the school, field training centres which are meant to provide practical experience for the student health visitor. The lack of any organised system of social service throughout the country greatly handicaps the efficient functioning of health visitors.

129. The form of training which has been found elsewhere to give the most satisfactory results is that devoted to the production of a public health nurse. This has proved to be more effective in operation and less expensive to administer than the provision of multiple specialised services such as maternity and child-welfare, school health and tuberculosis work. The public health nurse is a type of health worker hitherto unknown in this country. We may indicate her functions by the following quotations from an article entitled "Functions in Public Health Nursing" in the journal, *Public Health Nursing*, of November 1936.

"Public health nursing includes all nursing services organised by a community or an agency to assist in carrying out any or all phases of the public health programme. Services may be rendered on an individual, family, or community basis in home, school, clinic, or business establishment.

It is the responsibility of the public health nurse to assist in analysing health problems and related social problems of families and individuals; to help them, with the aid of community resources, to formulate an acceptable plan for the protection and promotion of their health, and to encourage them to carry out the plan. The public health nurse:

1. helps to secure early medical diagnosis and treatment for the sick;
2. renders or secures nursing care of the sick, teaches through demonstration and supervises care given by relatives and attendants;
3. assists the family to carry out medical, sanitary, and social procedures for the prevention of disease and the promotion of health;
4. helps to secure adjustment of social conditions which affect health and
5. influences the community to develop public health facilities through participating in appropriate channels of community education for the promotion of a sound, adequate community health programme and shares in community action leading to betterment of health conditions."

130. The nurse who can, in her relations with a particular family, be engaged in tuberculosis follow-up, prenatal care, the conduct of delivery and the subsequent postnatal care of mother and child has earned the position of a family friend, and one to whom the family will turn in their troubles. She becomes in fact the "Minister of Health" in the home.

131. The public health nurse who is to carry out this generalised type of nursing service should be a fully qualified certificated nurse and midwife. Her training will, however, differ to some extent from that of an ordinary nurse. The educational programme for her should stress, throughout, the preventive point of view. A curriculum should be worked out, which will carefully balance an integrated class room instruction in the science and art of nursing and in social studies with well-planned experience in hospitals, community health services and in the home. Experience of rural work

should be specially provided. The course of training for this class of health worker should be carefully worked out so as to suit Indian conditions. We therefore recommend that, in the first instance, the training of public health nurses should be organised in association with important training centres, where medical colleges and nursing educational institutions for the higher grade of nurses are provided. In these centres facilities for field training will also be available so that adequate opportunities can be provided for the trainees in public health nursing to acquire public health experience and to participate in domiciliary practice. At a later stage, in view of the necessity for providing a very large number of public health nurses to man our health services, it is suggested that nurses undergoing training in the ordinary training institutions might be attached, for specific periods of time, to the field organisations of medical colleges in order that they might obtain the necessary training in public health and domiciliary service.

132. We anticipate that, in due course, the need for facilities for training in community health work will increase considerably because we believe that nearly all types of health workers will require such training if they are to perform their functions satisfactorily. We have therefore provided, in each primary unit, associated with teaching institutions, housing accommodation for 12 trainees, who may at any time consist of doctors, nurses, midwives or other types of workers.

133. A course of four to five years should be sufficient to cover the general nursing, midwifery and public health training necessary. It must be made quite clear that, at present, there are no properly trained and qualified teachers or supervisory staff capable of conducting such a public health nurses training school in India. In building up such a staff it is hoped that advantage will be taken of the proposal made above to send selected Indian women abroad for study in connection with the more advanced problems of nursing education. It would be most suitable if, among the 36 students suggested for this study, some could be sent for specializing in the training of public health nurses, who would, on their return, co-operate in the work of the College of Nursing. In that way only, it is thought, can an adequate and comprehensive scheme be evolved for the development of this essential type of training. •

134. About 125,000 public health nurses will be required in British India alone by the time our long term programme is reached, taking into account the leave reserve necessary for the maintenance of the service. As an interim measure every effort should be made to impress on health visitors, during their training, the requisites of normal health, the preventive measures to be adopted against disease and the elementary principles of social medicine.

#### **D. Midwives**

135. Soviet Russia holds the midwife in such esteem as the agent who, above all others, entering the homes of the very poor, can instil there the principles of health and the care of infants, that an institute has been established in Moscow for the "protection of Motherhood and Infancy" the main function of which is to establish standards and supervise curricula for the training of midwives at the schools which have been set up all over the country. A two-

years' course of theoretical and practical training is given (Sigerist—Socialised Medicine in U.S.S.R.). It is interesting to note that, whereas the midwife is a standing institution in most other countries, she is almost unknown in the U.S.A.

136. In India today there are approximately 10,856 certificated midwives, and 662 assistant midwives registered by the Provincial Councils, but for the reasons that we have already given in the case of nurses, we feel that these figures are probably in excess of the correct number. It is likely that an accurate estimate of the number of midwives actually available for midwifery duties is in the region of 5,000. In order to provide one midwife for every 100 births, approximately 100,000 midwives will be required for British India and, to maintain that number, about 2,000 fresh pupils will have to be taken under training each year.

137. We have drawn attention elsewhere to the appalling rates of maternal and infantile mortality in this country and have adverted to the measures that should be undertaken to sever what is really the tap-root of the tree of ill-health, which overshadows the people of India. One of the most important of those measures is the provision of the services of a trained midwife for every confinement that takes place in the country. It will therefore be seen how essential it is to arrange for the proper training of this class of personnel in very large numbers.

138. The widespread efforts made in the past to attract Indian women of even a low standard of education to the profession of midwifery have, in most parts of the country, met with limited success. It is true that, in Madras, the situation is not so difficult as in other parts of India, a probable cause being the fact that the general level of education among women in that province is higher than in other provinces. We therefore feel that, for many years to come, it will be necessary to encourage the training of the indigenous *dai*. She as the hereditary midwife, has her recognised place in the Indian home throughout the country and she therefore seems to be a valuable agent for spreading all over India the practice of modern midwifery, provided she can be made, by adequate training, to render reasonably efficient service to the mother and infant during the discharge of her functions. We realise that the dead weight of ancestral tradition may be so heavy on her that, in attempting to educate a woman of this type, the success achieved may prove to be quite limited. Nevertheless, we feel that, in view of the magnitude of the problem and by the force of existing circumstances, the services of the indigenous *dai*, with such training as she can be made to assimilate, will have to be utilised over most parts of the country for many years to come. The type of training that may be given to her will be dealt with presently.

139. At present, instruction in midwifery is given both in English and in the vernacular languages. Courses in this subject vary from nine months to one year in the case of certificated nurses and from 18 months to two years for midwives. Only four provinces include domiciliary experience in the training—Madras, the North-West Frontier Province, the Central Provinces and Assam.

140. We are of opinion that midwifery training should be uniform for all nurses, the period of such training being one year for the

fully certificated nurse, whether junior or senior. On the other hand it should extend to at least 18 months for the midwife. In many training institutions, it is required that training in midwifery should form an essential part of the general training in sick nursing. While we value such training and feel that it gives a complete education to the nurse, we must draw attention to the enormous wastage that it involves. This wastage is two-fold. The bulk of those who receive midwifery training do not contemplate practising midwifery and as a matter of fact avoid it, restricting themselves to the field of sick-nursing. Secondly, many of the nurses trained in midwifery forget in course of time all that they have learnt and, when actually posted to perform such duties owing to their being technically qualified as midwives, are found unable to carry them out satisfactorily. In view of the urgent need for training a very large number of midwives, we suggest that until facilities are available for an increase in the number of training centres, midwifery training should be given only to two classes of people, (a) to the candidates who will follow the profession of midwifery and (b) to those certificated nurses who will run maternity institutions and hold the more responsible positions in the midwifery practice of the country. Training in midwifery will include training in sick-nursing, elementary anatomy and physiology, as well as in the problems of public health, particularly in their relation to infectious diseases, etc. A suggested course is given in Appendix 41.

141. It is proposed that, as for nurses, there should be two grades of midwives—junior and senior with equivalent basic standards of education. The minimum age for commencing training as a pupil midwife should be 18 years, though intending midwives will be eligible for the pre-nursing courses which we have proposed for inclusion in high school curricula.

142. *Training centres for midwives.*—These require considerable improvement and not all of them deserve recognition. The most serious drawbacks are:

- (i) lack of properly trained and well-qualified supervisory staff;
- (ii) lack of adequate facilities for ante-natal and post-natal work;
- (iii) lack of domiciliary practice and
- (iv) lack of opportunities for witnessing complicated cases of labour.

The present practice of admitting pupils in numbers based upon the annual number of deliveries in an institution is wholly illogical and no institution should be recognised as a training centre for midwives which does not meet the following fundamental requirements:—

- (i) there should be a minimum number of 500 cases of labour a year conducted within the hospital;
- (ii) there should be provision for antenatal cases being treated both in the inpatient and in the outpatient departments, with the minimum number of ten beds available for inpatients;
- (iii) in addition to the medical staff there should be a superior nursing staff qualified and experienced in midwifery;
- (iv) proper accommodation for pupil-midwives should be available in the training centre;



- (v) domiciliary practice within easy reach of the hospital training centre should be available, under adequate supervision and with facilities for transport and
- (vi) a properly equipped teaching centre with models, diagrams, specimens, and library facilities should be available.

The training can be given either in English or in any of the Indian languages, but if training is given through Indian languages the person who gives this training should himself or herself be a practising obstetrician holding a senior and responsible post in the hospital. The method by which teachers in midwifery are appointed, more on the basis of their linguistic qualifications than on their professional attainments, should not be encouraged.

143. *Text-books*.—As in the case of nurses, so also in the case of midwives, there is a great need for up to date text books. These could be arranged by the Editorial Board, which has been suggested earlier, in such languages as Tamil, Telugu, Canarese, Malayalam, Marathi, Gujarathi, Hindi, Urdu, Bengali, Sindhi, etc.

144. *Revision courses*.—There is little use in making elaborate arrangements for the original training, if no provision is made for refresher courses, which will enable the midwife to learn about advances in her profession. It must not be forgotten that the midwife works largely by herself and often in out of the way places, while the nurse works usually with medical men who help to keep her up to date. It is, therefore, evident that the need of the midwife for such courses is very real and we suggest that they should be arranged at intervals of five to seven years in all training institutions for midwives and that all midwives should be required to attend them at those intervals during their professional career.

#### E. *Dais*

145. We have already expressed the view that the continued employment of these women will, for a period, be inevitable. A trained *dai* is obviously better than an untrained one, and a scheme must be elaborated by which it may be possible to get the most effective use out of this type of personnel. For the successful working of such a scheme certain matters require consideration. The *dai*, as the hereditary midwife, has great influence over the people and any plan which fails to secure her active co-operation may stand little chance of success. One of the reasons underlying the hostility shown by the *dai* is the fear that the restrictions that the health authorities may introduce will probably deprive her of the emoluments to which she has been entitled in the past. Another is the feeling of scepticism with which the human mind looks on all innovations. With her conservative outlook and lack of education she finds it difficult to believe that her traditional practice of midwifery is faulty and that the new methods suggested by the health authorities are an improvement on her own. An essential feature of our scheme should therefore be to secure her confidence by dispelling her fears regarding the probable loss of her established rights to certain emoluments and to attempt, only by stages and with a sympathetic understanding of her own background of ignorance and prejudice, to win her over to the adoption of certain necessary changes in her traditional practices.

146. One of us (General Hance) has had considerable experience in developing a midwifery service through trained *dais* in North-West Frontier Province. The first attempt was made in Dera Ismail Khan. Two health visitors were placed in charge of the scheme. The local *dais* were invited to report to the health authority the confinement cases they were called in to undertake. When such reports were made, one of the health visitors went, on each occasion, to the house concerned and attempted, with tact and a sympathetic handling of the *dai*, to improve her practice of midwifery through such simple methods as the washing of hands before assisting in the confinement and the avoidance of interference with the normal course of delivery. For each case that was brought to the notice of the health authority a fee of Re. 1 was paid to the *dai*. It was made quite clear to these women that there was no intention to deprive them of their legitimate income and that the purpose of the health visitors' visits was to help the *dais* with such advice and guidance as would prove useful to them. Thus, in course of time, there developed an atmosphere of mutual trust and friendly co-operation, which facilitated the starting of the next stage of the experiment.

147. Selected *dais* were taken for training in midwifery in the local hospital. They were given food, lodging and a stipend during the period of training and, when they went back to work, they accepted with greater willingness than before the help and guidance of the health visitors in the conduct of the deliveries they had to handle. The domiciliary midwifery service which was thus developed was based on the hospital, the two health visitors acting as the agents for carrying out skilled supervision of the work of trained *dais*. Through antenatal and postnatal clinics established at the hospital, health visitors and trained *dais* were encouraged to persuade expectant mothers and women after childbirth to attend the clinics for suitable advice and treatment. The hospitalisation of difficult cases of labour was also facilitated through the co-operation that was established between that institution and the trained *dais*. It will thus be seen that, although in a limited way, a co-ordinated scheme of institutional and domiciliary midwifery service was developed in the area by utilising the services of trained *dais*. The success of the scheme was founded on the absence of compulsion and on the enlisting of the interest and co-operation of the hereditary midwife by disarming her of her fears and suspicions regarding the intentions of the local health authority.

148. We understand, from another member of our committee (Dr. Butt), that the attempt to train indigenous *dais* and improve their normal practice of midwifery has been found equally successful in the Punjab.

149. In selecting *dais* for training experience has shown that it is difficult to wean elderly women from their established habits and that the more intelligent among their daughters and daughters-in-law provide suitable material for such training. When devising the course of study it should be borne in mind that *dais* working in urban and rural areas require a somewhat different type of training. In both cases emphasis must be laid on certain common matters, which include the diet in pregnancy, the hygiene of pregnancy, the danger signals to be looked for, the various presentations, the conduct of labour with the minimum of interference and the importance of

giving up certain bad habits of midwifery known to be practised by indigenous *dais*. The better facilities for hospitalisation and for antenatal and postnatal care that towns generally provide point to the desirability of emphasising, in the training course for the urban *dai*, the need for sending expectant mothers to maternity and child welfare centres for periodical examination and treatment and for advising all women with any abnormality or adverse medical condition to seek admission into hospital for delivery. In the absence of equal facilities for medical care in the rural areas, the training of the rural *dai* should lay special emphasis on danger signals and abnormalities, the precautions to be taken under such conditions, the availability of skilled attention in the neighbourhood and the methods of transporting the patient to hospital with the least possible risk to her health. In both cases the training should include the experience of midwifery under hospital conditions and in the homes of the people. Hospital and home conditions are so different that we consider experience of domiciliary practice essential. We recommend that, during training, a minimum of ten domiciliary cases of confinement should be carried out by each *dai*. At first the latter should watch a certain number of such cases conducted by the health visitor and she should later conduct them herself under the supervision of the health visitor.

150. Two essential features of any scheme for a midwifery service through *dais* should be the provision of (1) adequate supervision and (2) facilities for refresher courses. Under our scheme there will be, during the first five years, a dispensary with two maternity beds at the headquarters of each primary unit as well as a 30-bed hospital to serve the needs of four primary units. In the next five years the number of such hospitals will be doubled so that each will serve two such units. We recommend that the training of *dais* should be started, on the lines indicated above, at each of the 30-bed hospitals and primary unit dispensaries. The services of the four health visitors attached to each primary unit can be utilised for initiating work on the lines which has been followed in Dera Ismail Khan. Such preliminary work directed towards winning the confidence of the local *dais* is of the utmost importance. Later, a combined institutional and domiciliary service for mothers and children can gradually be developed, the 30-bed hospitals and the dispensaries with their maternity beds taking their share in the proposed programme. The women doctors attached to the primary units and the health visitors can take a prominent part in the development and maintenance of such a service.

151. In British India the annual number of births is probably in the neighbourhood of ten millions and, even if a proportion of this large number of expectant mothers is to receive skilled attention during pregnancy and childbirth, the need for enlisting the services of the indigenous *dai*, as an interim measure, cannot be over-emphasised. It is recognised that, even after such training as she may be given, the *dai* is not likely to prove as satisfactory as a qualified midwife and that the danger of such an imperfectly trained person is that she may lapse into her old and undesirable habits. One of the reasons for such return to old habits was, in the past, the inadequacy of provision for supervision over the work of trained *dais*. The four

health visitors working in the relatively small area of a primary unit should be able to provide a much higher degree of supervision than could be exercised in the past. Another method of ensuring a reasonable measure of efficiency is by providing refresher courses for *dais*. Such training should be available at least at intervals of two years. The 30-bed hospitals and the dispensaries with their maternity beds will have to perform this function also.

152. We must emphasise, at the same time, the need for proceeding with the training programme for midwives on the lines indicated by us. The purpose in view is not, however, to deprive the *dai* of her hereditary profession through her replacement by trained midwives from other classes of the community. We believe that, with the development of the postwar educational programme, most of the younger women of the *dai* community will, within the next fifteen or twenty years, become sufficiently educated to qualify themselves for the full course of training prescribed for a midwife. The programme of *dai* training described in the previous paragraphs, with its special emphasis on a sympathetic understanding of the existing disabilities of these women, will also have helped, it is to be hoped, to turn large numbers of that community into active collaborators with the health department in the provision of midwifery service to the people. In these circumstances what we anticipate is that increasing numbers of the younger women of the *dai* community will become available, as the years go by, for the complete training of a qualified midwife and that these will form the vast majority of those who are employed in the State midwifery organisation. Thus the objective we have in view is the upgrading of the existing class of hereditary workers in the field of midwifery in the country into fully trained and efficient workers.

153. The subjects of control over the standards of training required for nurses, health visitors and midwives and of their control from the professional point of view have been discussed in Chapter XXII(c).

#### **F. Nursing Orderlies and Ward Ayahs**

154. At present no regular training is given for these workers. It is very desirable, however, that they should be given an elementary understanding of the principles of hygiene, the cause and spread of disease and the methods to be employed for protecting themselves and others. They should be instructed also in the routine and non-nursing duties of a nurse, and should be capable of relieving the latter in the carrying out of these, so that she may be more usefully employed on her professional duties. At the same time, they should in no case be taught, or expected to give, nursing attention to the sick.

### **(VI) HOSPITAL SOCIAL WORKERS**

155. Hospital social service brings to the care of the sick in institutions such knowledge of their social conditions as will hasten and safeguard their recovery and help to prevent any recurrence. Such knowledge enables those responsible for their treatment to understand and treat the patients' illnesses more effectively. In the carrying out of her duties the medical social worker has become, in fact, an assistant to the physician in the diagnosis and treatment of disease.

156. The medical social worker is comparatively a new comer in the field of medical service. She is called upon to use her professional skill and knowledge in efforts to effect desirable changes in the relationship of the patient and his physical and human environments. She is also being increasingly recognized as an essential professional colleague of the physician in the analysis and treatment of the physical and emotional disturbances of his patients. When the physician discovers or suspects the existence of social maladjustments it should be his duty to refer the case to the social worker, defining for her the specific social and emotional disturbances which he suspects to be holding up effective treatment.

157. The duties of a hospital social worker may therefore be divided broadly into two main sections, the one constructive or positive, and the other negative or semi-negative, and in a summarised form they may be stated as follows (Stone—*vide infra*):—

- “(a) Discovery and making available to the medical staff any factors in the patient's environment that may have any bearing on his physical condition, thus supplementing medical history by social history. This would include any facts of heredity, personality, manner of life, home environment, worry about finances, dependents, character of employment and strains and hazards incidental thereto, recreations and standard of living generally, or shortly all facts that may influence diagnosis and affect the plan of treatment.
- (b) Influencing and guiding patients in carrying out treatment by making the physician's directions simple and concrete, and helping them to carry out the plan of treatment through to completion.
- (c) Overcoming obstacles to successful treatment or recovery, particularly in the out-patient department, and during convalescence. Under this head also, it may be necessary to see that medical and surgical supplies (instruments, spectacles, teeth, etc.) are secured; that social or economic conditions affecting the patient adversely are corrected, and that as far as possible a situation favourable to recovery is secured. This last may mean new employment, temporary financial assistance, relieving patients of responsibilities for care of children, special assistance with food, etc. It will also include the provision of sanatorium or convalescent treatment where advised by the medical staff.
- (d) Arranging for supplementary care of patients. This is the positive side of this second requirement and is treated under heading number 3. This and the next duty will require a thorough knowledge of the powers and duties of all the available social and health agencies of the country.
- (e) Educating the patient in regard to his physical condition in order that he may better co-operate in the programme laid down by the physician, this programme providing not only for the cure of illness, but the promotion of

health with a view to the prevention of illness. Without this service much valuable and expensive treatment would be wasted because of its ineffectiveness.

- (f) Discussing with patients their resources, and collecting, if required to do so, their contributions towards the cost of the treatment given.
- (g) Checking the abuse of hospitals, both as to out-patients and in-patients, who on examination are found to be :
  - (i) in a position to pay for treatment;
  - (ii) persons insured under the National Health Insurance Acts, entitled to the services of a panel doctor, and not requiring special hospital treatment.
  - (iii) beyond the power to benefit by any assistance other than that obtainable through the Public Assistance Committee."

158. It is evident that, in any progressive scheme for the development of Social Medicine along these lines, it is essential that workers of this type should be brought under active instruction as quickly as possible. The chief difficulty at the moment is to obtain any adequate training in India. It is a training which cannot be undertaken by amateurs, or by the method of trial and error.

159. An attempt has been made at the Sir Dorabji Tata Graduate School of Social Work in Bombay to develop courses for social workers, and we have had the benefit of discussion with the Director of that school. It appears that the two year graduate courses at present being given, in addition to the pre-professional and general courses, cover the following:—

- (1) Family and child welfare.
- (2) Juvenile and adult delinquency.
- (3) Industrial relations and labour problems.
- (4) Administration of social work.
- (5) Medical lectures for social workers.
- (6) Medical hygiene and psychiatry for social workers.
- (7) Social and family case work.

These courses as they stand are too specialized and restricted and would require considerable modification and expansion in order to meet the needs of a hospital service.

160. For the guidance of those who will have to devise suitable courses for India in this important department, reference should be made to the following authoritative works:

- (1) 'Hospital Organisation & Management' by Captain J. E. Stone—chapter 22 and
- (2) 'Hospital Organisation & Management' by M. T. MacEachern—chapter 12.

161. The training of a hospital social worker is the same whatever the field in which she will eventually work, but Psychiatry is an exception. The education of a psychiatric social worker requires a different training and different examinations. In addition to the general training referred to above, a candidate must spend an extra year in specialised training. The main functions of such workers are

described in the Interim Report on Social and Preventive Medicine by the Royal College of Physicians (October 1943) as follows:—

- (1) To obtain social histories by means of which the psychiatrist is enabled to see the patient more clearly against his domestic and wider social background.
- (2) To ensure that the patient's relatives, or others close to him, provide as far as they can the psychological and material environment judged necessary to further his recovery and maintain his mental health.
- (3) To bring the resources of the community to bear on the patient's needs, *e.g.*, by referring some of his problems, to employers, relief agencies, social clubs, etc., which can help him, and by aiding him to make the best use of the available facilities.
- (4) To ease by after-care the difficult transition, from more or less dependent patient to self-reliant member of the community.
- (5) To carry out systematic social investigations needed for assessing the causes of good health and illness, the effectiveness of treatment, or other matters of medical and social import.
- (6) To educate the public—incidentally, in the course of her work—to take a sensible attitude towards mental health she is well-placed to do this, and is a fitting intermediary. Teaching the public to discard harmful prejudices and to act promptly to nip illness in the bud will be the special worker's business as well as the doctor's.

162. We consider it extremely desirable that suitable persons should be sent without delay to foreign countries where this branch of health work is receiving special attention, in order to acquire the necessary training and to study what is being done in those countries. On their return to India, they should be employed in initiating training schools for hospital social workers.

#### (VII) THE TRAINING OF TECHNICIANS

163. In the great advance of medical science in recent years the need has increasingly developed for a large ancillary army of workers to assist the medical practitioner in those technical details and processes which would otherwise fritter away his energies, and in order to allow him adequate time to devote himself to the more strictly medical aspects of his profession. These technicians, who form a highly specialized group of personnel, may be broadly classified under the following heads:—

- (1) Laboratory technicians.
- (2) Radiographers.
- (3) (a) Occupational therapists.  
(b) Physical therapists.

164. In India courses of training have not reached an adequate standard except in Madras, though several Missionary institutions

have made a beginning in this direction—notably the Christian Medical Association of India, which has instituted a training school at Union Mission Tuberculosis Sanatorium, Arogyavaram.

165. In the U. S. A. the training of occupational and physical therapists and of clinical laboratory technicians is governed by the Council of Medical Education and Hospitals of the American Medical Association. According to the last published report (Jl. Am. Med. Assoc. March 22, 1941) every physical therapist technician had, in that year, an average of 12 months training in addition to a preliminary qualification either as a physical educator or as a nurse, and 275 students were in training in 15 approved schools. There were, at that time, some 200 schools training clinical laboratory technicians. In China training schools for technicians have been in operation for the last 20 years with 6—12 months courses in laboratory techniques. In Russia there has been an increasing demand for this type of personnel, trained in a one year course. A unique feature of the Russian technicum is that individuals who complete a technical course for a specified period and, at the same time, satisfy the requirements of a medical worker's faculty which is designed to train daily workers for higher education, may proceed to study for a medical qualification.

### **Laboratory Technicians**

166. The laboratory technician or medical technologist has been defined as "a person who by education and training is capable of performing the various chemical, microscopic and bacteriological tests used in the diagnosis and treatment of disease under the supervision of a qualified physician or clinical pathologist."

167. Schools for the training of such technicians should be organised by universities, colleges of medicine, well-equipped hospitals and public health laboratories. The responsibility for training in hospitals should be placed on the hospital administrative staff, while in the colleges and universities this responsibility should be laid upon the controlling Board. Every such school should have a competent teaching staff, the Director of which should be a graduate in medicine and a pathologist of recognized ability who should take part in, and be responsible for, the actual conduct of the training course. Not more than two students should be attached for laboratory practice to each senior member of the teaching staff of each department.

168. Laboratory technicians may be trained either in the Departments of Anatomy or Physiology of a Medical School, or in the Departments of clinical laboratory sciences, Pathology, Bacteriology and Pharmacology. Each student should receive practical training, adequate in kind and extent under competent supervision in a hospital laboratory. Such a hospital should have a minimum of 2,000 admissions, and an average of 15,000 tests and examinations carried out in the laboratory department annually. Adequate space, light and modern equipment should be provided in the Laboratory department, while there should be a library with up-to-date reference books and periodicals. A satisfactory record system should be provided for all work carried on in the Department. Candidates for admission should preferably be persons who have completed the Secondary School Leaving Certificate or the Matriculation examination with Science as one of the compulsory subjects of study.



169. A laboratory technician may qualify himself in either of the following two groups—

- (1) Anatomy and Physiology (for work in those departments).
- (2) Pathology, Bacteriology and Biochemistry (for specific laboratory work).

The period of instruction for each of these groups should be two years. Courses considered suitable for this purpose are detailed in Appendix 42.

### **Radiographers**

170. The radiographer assists the radiologist in a manner similar to that in which the dental hygienist assist the dental practitioner. He sets the radiologist free in fact for the finer details of his specialized practice.

171. The training of this type of personnel has, naturally, to be undertaken in an Institute or Department of Radiology and Physico-electric therapy. The standard of entrance should be the Intermediate Science, preferably with mathematics or a pre-degree examination of an analogous standard. A suitable course of training designed to extend over two years is set out in Appendix 43.

### **Examinations**

172. An examination should be held at the end of each year's course. The examiners should be appointed by the examining body, which should issue certificates to the successful candidates after the completion of 2 years' course. It is desirable that no examination fee should be charged. If this is not possible, then only a nominal fee of Rs. 10 or less, depending on the conditions prevalent in a province, should be paid by the candidates.

In the case of both the above classes we propose that the Examining Body should be a Board constituted by either the Ministry of Health or by the Administrative Medical Head of the Province.

### **Tuition Fee and Caution Money**

173. No fee should be charged for the training, but the candidates will have to deposit caution money of Rs. 50 in the case of a laboratory technician and Rs. 100 in the case of a radiographer. This exemption from the payment of fees is suggested in consideration of the fact that candidates will be doing work for the department during the course of their training.

### **Registration.**

174. Adequate consideration must be given to the question of registration of these technicians and, as a guide to the establishment of such a register, an extract is given as Appendix 44 from the 10th edition of a booklet describing the function of the Registry of Medical Technologists of the American Society of Clinical Pathologists.

### **Occupational and Physical Therapists**

175. There are at present no regular arrangements for the training of such therapists in India. It is very desirable that schools should be established at an early date which will supply adequate

training in the rehabilitation of the sick. We do not feel that, at this stage, we can offer any concrete proposals for such training but suggest that, in the near future, experts from abroad, if necessary, may be brought to India temporarily, and also that selected persons with adequate qualifications may be sent abroad to study the problem with a view to the establishment of schools and courses of training suitable to the needs of this country.

As a guide to those who may have to organise these courses we have included in Appendix 45 of the set-up proposed by the Council on Medical Education in Hospitals of the American Medical Association for schools for occupational therapists, physical therapists and clinical laboratory technicians.



## CHAPTER XIX

### MEDICAL RESEARCH

#### Introduction

1. A study of the present state of existing institutions, which is fully set out in the survey section of our report, will show quite clearly how great is the need for the improvement, expansion and development of medical research in India in all its branches. The outstanding defect at the present time is the almost complete absence of organised medical research in the various departments of the medical colleges. It is true to say that, apart from a few noteworthy exceptions, research in these institutions has been very badly neglected. The chief factors concerned are: (1) ignorance on the part of the authorities of the importance of research in relation to the maintenance of a high standard of teaching and the development of the right attitude of mind in the student; (2) insufficient personnel of the right type; (3) the prevalent practice of employing part-time teachers especially for clinical subjects and the consequent necessity for teachers to engage in private practice in order to make a reasonable living; (4) insufficiency of suitable equipment and, in some cases, lack of adequate accommodation and (5) inaptitude for, or lack of interest in, research on the part of many of the teachers employed. No proper facilities exist in India for training the young, alert minds of the country in a scientific approach to medical matters and this lamentable deficiency probably accounts for the indifferent attitude to research on the part of many of the teachers in medical colleges.

2. Organised medical research in India at the present time depends, to a large extent, on the Central and Provincial Government institutes, on the small cadre of officers of the Medical Research Department and on the Indian Research Fund Association, which has hitherto functioned mainly through the agency of these officers and institutes. The opportunities for the conduct of research in Central and Provincial Institutes have diminished progressively in direct proportion to the increase in volume of the routine duties which they have been compelled to undertake, usually without any corresponding increase in staff. The Central Research Institute, Kasauli, for example, was originally constituted for the primary purpose of undertaking investigations both in the laboratory and in the field, but it has been compelled to undertake such a heavy burden of routine work that, in recent years, research work has become, at best, a spare-time activity of enthusiastic individuals. In fact, research on any appreciable scale has been possible in recent years only when additional personnel, material and equipment have been made available through grants-in-aid from the Indian Research Fund Association. The same trend has been apparent in most of the Provincial institutes. It is important fully to realise this throttling effect of routine work on research even in laboratories in which research was intended to be the primary function. There are at present few facilities for post-graduate training in teaching and research in medical subjects. Such as are available are centred chiefly in the Calcutta School of Tropical Medicine and the All-India Institute of Hygiene and Public Health.

3. The opportunities available in India for the investigation of many medical and public health problems are as good as, if not better than, those in almost any other country. It is true to say

that, in the past, India has been in the forefront on such major health problems as malaria, cholera and kala-azar and has taken a prominent part in the investigation of such other important problems as rabies, plague, leprosy, the dysenteries and nutrition. Nevertheless, the achievements of the past have not been commensurate with the unequalled material available for research or with the pressing needs of the country.

4. While it has been freely admitted that the Indian Research Fund Association has fulfilled a useful function within the limits imposed by the financial resources at its disposal, it is generally felt that research as at present organised is narrow and restricted, and that there is an urgent need not only for it to be organised on a broader basis but also for making funds much more freely available for research work. Hitherto the Indian Research Fund Association has been the chief organisation in India which has subsidized research. The amount of money available for distribution has been only about Rs. 4 lakhs per annum, an allocation which is considered to be miserably inadequate to meet the needs of medical research in a vast sub-continent. Provincial Governments, with a few exceptions, have taken little interest in medical research and have not been prepared to spend money on it.

5. Within recent years great advances have been made in India in the production of pharmaceutical and biological preparations by private enterprise. It may be accepted that some of the firms engaged in work of this kind are already well established although the standards so far achieved, at least in so far as the preparation of biological products is concerned, are not, in all cases, entirely satisfactory. It is apparent, however, that this trade has come to stay and it will be wise to foster and encourage it with such safeguards as are essential to protect the public interest. India provides a vast market for preparations of this kind and, if this young industry is carefully nursed it should eventually be able to meet most, if not all, of the requirements of the country.

We shall now proceed to examine the possibility of remedying these defects and to make proposals for future development.

### **I. Organization of Medical Research in India**

6. The criticisms made of the existing organization for medical research in India have already been cited. Organizations for medical research in other countries were examined in detail including the Medical Research Council in Great Britain, the National Medical Research Council in Canada, and the national Research Council in the United States, all of which have contributed greatly to the furtherance of medical research in their respective countries. A common feature of all these organizations is that they enjoy great latitude in the formulation of their research policy and complete freedom in the disposal of the funds allotted to them. We are unanimously of the opinion that in India some similar central body for medical research is essential. We consider that this should be constituted as a separate autonomous organisation unfettered in the formulation of its research policy and vested with full powers to hold and disburse moneys allotted to it from public funds, or placed at its disposal by private benefactors. We recommend the constitution of a statutory organisation consisting of:—

(1) a Scientific Board, which would be the executive machinery of the organisation and

(2) an Administrative Body which would form the link between the Board and the Government of India and exercise general supervision over the working of the organisation.

(1) The Scientific Board

This Board would undertake the executive responsibilities of the organisation for the furtherance of medical research. The Board should include the following:—

- (a) Medical research workers of standing and experience.
- (b) Representatives of universities and medical colleges.
- (c) Representatives of the principal scientific bodies in India.
- (d) Prominent workers in the field of public health and clinical medicine.
- (e) Non-medical representatives of allied and fundamental sciences.
- (f) Persons with experience of health administration.

The work of this Board should be aided by the formation of an adequate number of expert advisory committees for special subjects.

(2) The Administrative Body

We suggest that it should have the following type of membership:

- (a) The Minister of Health in the Central Government.
- (b) Representatives of Government Departments for Agriculture, Industry, Labour and Finance.
- (c) One representative of the Council of State.
- (d) Two representatives of the Legislative Assembly.

The Director General of Health Services with the Government of India should be in attendance at all meetings of this body.

The Board would make recommendations regarding the allocation of funds for the furtherance of research to the Administrative Body, in which would be vested the power of giving sanction to such allocation.

(3) A wholtime Secretary specially selected for his scientific eminence, organizing ability and driving power should be appointed for this statutory organization.

The majority of us consider that, if a National Research Council of India should be formed at some future date, the proposed central organisation for medical research should become a Division or Board of this Council, though some of us are of the view that, though the closest liaison with it should be established, the question of ultimately incorporating the research organisation in the National Research Council might be left for decision at a later date.

The functions of the central medical research organisation proposed above would be:—

- (a) Formulation of policy in regard to the future development of medical research in India and the co-ordination of all medical research activities.
- (b) Stimulation of research activities in universities and medical colleges and arrangements for exchange of associate professorships with this end in view.

- (c) Responsibility for the selection and training of medical research workers.
- (d) Constitution of an adequate number of expert advisory committees for special subjects.
- (e) The promotion of research programmes and the allocation of funds for, or in aid of, their conduct.

These functions would be exercised by the Scientific Board constituted as in (1) above under the general supervision of the administrative body constituted as in (2) above.

We also recommend that the Indian Research Fund Association should be merged into the Central Medical Research Organization now proposed.

## II. Medical Research in Teaching Institutions

### 7. Postgraduate Teaching Institutions—

There are only two highly-organized and developed medical postgraduate teaching institutions in India at the present time, namely, the Calcutta School of Tropical Medicine and the All-India Institute of Hygiene and Public Health, Calcutta. In each of these, advanced courses of instruction, as outlined in Vol. I of this report, are given and research work of a high order is regularly carried out. Both are capable of further development and the lines on which this should, in our opinion, be carried out are given below:—

(a) *School of Tropical Medicine, Calcutta.*—This School is for all practical purposes an All-India Institution and it should therefore be, largely, if not wholly, a Central Government responsibility. At the present time students, teachers, research workers and patients are drawn from all parts of India and even from beyond its frontiers. Up to now the Government of Bengal has met the greater portion of the expenditure incurred, although much of the money available for research work has been derived from other sources, in particular from industrial concerns, from the endowment fund of the School and from the Indian Research Fund Association.

The work of the School is at present greatly handicapped by lack of sufficient accommodation. The various departments are so overcrowded that their research activities are impeded and it would be virtually impossible to accommodate any appreciable number of postgraduate students. For this reason, training facilities of an exceptionally suitable nature are denied to many potential teachers and research workers.

At the present time, the work of the School is decentralized into nearly twenty so-called departments, each of which covers only a very limited sphere of work. This has the disadvantage that, from the point of view of training young graduates, individual departments do not afford a sufficiently broad basis for training purposes, and furthermore research work on narrow specialities is liable to be carried out in water-tight compartments. It is true that the Professor of Tropical Medicine acts as co-ordinator of research, but it would probably be more satisfactory if research work was co-ordinated after several of the departments had been amalgamated under better and more direct supervision.

There are very strong reasons for retaining the School and its associated hospital in its present location and there is an urgent necessity for greatly increased accommodation to allow of the proper

conduct, and of the further development, of the work of the School. Unfortunately, the possibility of providing increased accommodation on the present site appears to be remote as there are no vacant sites in the immediate vicinity. The most obvious remedy would be for the School to take over the large, modern and well-equipped laboratories at present occupied by the All-India Institute of Hygiene, which is situated immediately adjacent to the School. This would provide immediate relief for the present congestion and would leave room for future development for many years to come. As a first step in placing the School on an all-India footing, it would be fitting if the Government of India were to gift these buildings to the School. This would, of course, entail the provision of new accommodation for the Institute on an equivalent, or preferably more generous scale elsewhere.

Given suitable personnel and the opportunity to expand by providing improved and enlarged accommodation, the School may safely be left to develop into a centre for teaching and research on tropical medicine second to none in the world. As has already been pointed out, the clinical material and other facilities available are unparalleled. The fullest use should be made of these facilities in developing centres for the training of teachers and research workers.

We emphasize the need for additional organizations of this kind at other important centres in India.

(b) *All-India Institute of Hygiene and Public Health*.—The All-India Institute of Hygiene and Public Health is much less overcrowded, and is organized on a much broader basis than the Calcutta School of Tropical Medicine. If all the accommodation in the Institute buildings were made available to the legitimate departments of the Institute, space would be sufficient for present needs.

The Institute has hitherto failed to fulfil one of the primary functions for which it was established, namely, the investigation of methods of applying knowledge of medical protection to large community groups. Recently, a collaborative scheme between the Government of India and the Government of Bengal has placed under the control of the Institute a large area near Calcutta where opportunities will be available for investigations of this kind. The research activities of the Institute should be directed to the solution of problems of two main types. In the first place, research is required in order to develop effective methods of public administration best suited to the social and economic conditions prevailing in India. In the second place, the development of such methods will raise problems for the elucidation of which knowledge is not at present available and research will therefore be required. For example, the provision of a safe water supply must be based on proper water standards for the working out of which collaborative research between the sections of microbiology, chemistry and epidemiology will be necessary. The investigation of efficient methods of applying knowledge may well raise other problems for the solution of which the co-operation of other institutes such as the departments of the natural sciences of a university may be required. The evolution of the present methods of controlling yellow fever provides a classic example of the necessity for collaboration with the pure physicist. In brief, the chief research activities of the Institute should be directed to the solution of problems of administration designed to facilitate the adoption of practical recommendations by

the most efficient methods. The Institute would thus serve as a staff college for administrative health officers.

### 8. Medical Colleges

In order to rectify existing conditions in the medical colleges of India as regards the conduct of research work, a drastic overhaul will be necessary. This is a matter which concerns, primarily, professional education. A complete change of outlook towards research in the various departments of the medical colleges in India must be achieved, and a greatly increased number of properly trained workers must be provided in order to establish active research centres in the medical colleges. This subject is discussed in some detail in the section of this report dealing with the recruitment and training of medical research workers, but may be summarised here as follows:—

(1) The importation, for short periods, of medical research workers of recognized standing.

(2) The appointment of associate professors, financed, if necessary, by the Central Medical Research Organization, to conduct and stimulate research.

(3) Exchange professorships.

(4) The provision of scholarships for selected young workers including promising young graduates in the basic sciences.

Primary requirements in establishing research centres in the medical colleges are: an increase in the number of properly trained personnel; the retention of wholtime workers; the provision of adequate emoluments; liberal provision for study leave; the prohibition of private practice and the provision of better accommodation and equipment.

In our view the departments of the medical colleges, both clinical and pre-clinical, provide the most favourable and most desirable location in which to establish research centres.

## III. The Recruitment and Training of Medical Research Workers

9. We recognize that the number of suitable medical research workers and the facilities for training them are at present inadequate in India, and that before any expansion of medical research can be undertaken, the primary requirement will be a great increase in the number of properly trained workers available. No extension of medical research will be possible until this requirement is met.

10. We consider that responsibility for recruiting medical research workers, and for the creation of training centres for them, must be a primary function of the central organization for medical research, and that this function should be freely exercised at the earliest possible moment. The following methods are recommended to achieve this end:—

- (1) The provision of scholarships to facilitate the training of young workers in the universities, medical colleges and other laboratories and institutions in India; in numbers up to the capacity of these institutions to train them adequately. Promising young science graduates who might eventually be suitable for medical research work but who are unable to meet the expenses of a



medical education, should be given scholarships for this purpose or directed into lines of work in which their training may enable them to take up research on subjects allied to medical research, with the necessary financial and other assistance.

- (2) To facilitate such training, the services of workers of recognized standing in different branches of medical science should be obtained for short periods for attachment to suitable medical institutions. The duty of these workers will be to conduct research on selected subjects in which young scholars and graduates would be associated.
- (3) The provision of an adequate (and annually increasing) number of scholarships for young Indian graduates (medical and non-medical) tenable abroad for a period up to three years, to enable them to receive advanced training in special fields of study. Candidates for this type of scholarship might suitably be selected from amongst those trained as suggested in (1) and (2) above. Those selected for scholarships for training abroad would be required to devote their energies to acquiring specialized knowledge of the subjects in which it was intended that they should be employed on return. They should not acquire academic degrees or diplomas without the express sanction of the sponsoring authority.
- (4) The formation of active research centres in universities and medical colleges in India by the appointment of associate professors, selected by the Central Medical Research Organization, for the express purpose of providing facilities for the advanced training of senior students and graduates, so as to interest them in, and fit them for, research careers.

11. We recognize that medical graduates are unlikely to undergo the necessary training for a research career unless subsequent employment in such work can be secured for them and consider that arrangements for this must be a further responsibility of the Central Medical Research Organization which has selected the graduates and has arranged for their training. We therefore suggest that, in consultation with the authorities concerned, subsequent employment might suitably be arranged in (1) the proposed All-India Medical Institute; (2) a Central or Provincial laboratory or institute where their services could be suitably employed; (3) a university or medical college as associate professors or research workers; and (4) any suitable field of medical or public health work in which their training and experience would be of value.

12. The Central Medical Research Organization must, where necessary, be prepared to meet the emoluments of trainees until such time as they are absorbed into regular employment, or have ceased to be productive in the field of research.

13. We recommend that the terms and conditions offered to medical research workers should be such as to provide reasonable security and to ensure freedom from financial worry. It is not recommended that workers should enjoy such a degree of permanency as might

tend to foster indifference and lack of effort. Adequate scales of pay with provident fund benefits are recommended, and continued employment should be given to all who retain their capacity for fruitful research. Work should be subject to periodical review and in those cases where a worker has lost his powers of original work, his services should either be dispensed with at the conclusion of his contract, or, if he is otherwise an industrious and efficient worker, every effort should be made to find him employment of a more routine nature so far as this may be possible.

14. Although we have dealt with the question of training teachers and research workers in various branches of medicine in other places in this report, we may set out here certain principles which should govern the development of provision for such training.

*Objective.*—The object should be to develop teachers in the various branches of medical science whose competence is based on personal ability, and experience gained through teaching and independent research in their own fields.

*Selection of Trainees.*—Trainees should be selected from distinguished graduates in medicine or graduates in science, with honours or post-graduate qualifications, and should be chosen by a personnel selection board on lines now employed by the Army Medical Service—primarily on a basis of aptitude for, and attitude to, scientific studies. A satisfactory health record should be essential for acceptance.

Science graduates should be eligible for training in the pre-clinical fields and may be required to attend courses in selected medical subjects for orientation.

Medical graduates who have completed their curriculum, except for the intern year, should be eligible for training in the pre-clinical fields if the intern year has been spent in the department concerned.

15. *The Course of Training.*—We recommend that the minimum period of training should be four years including the intern year. Science graduates should enter training as interns in the department concerned. In the case of those who have already had experience of teaching, the period of training may be of shorter duration. The details of the course of training recommended are outlined briefly in Appendix 46.

16. In order to implement the suggestions made above we specifically recommend:—

- (1) the creation of an All-India Medical Institute,
- (2) the establishment of post-graduate training institutions in different provincial centres for subjects which will not be included in the programme of the All-India Institute, and
- (3) the development of a number of teachers training departments as a short-term policy to initiate postwar development.

As regards (1) and (2) our specific recommendations have been set out elsewhere in this report.

We consider that immediate action should be taken to make possible all the three recommendations set out above.

#### **IV. The Future of Medical Research in Existing Government Institutes and Laboratories**

17. Existing institutes and laboratories under the Central and Provincial Governments have fulfilled important functions in the past and we recommend that these should not only be continued but extended.

18. It has been the universal experience in India that research in the Central as well as in the Provincial institutes has been progressively encroached upon by an ever-increasing volume of routine work. We therefore consider it imperative that any institution created for the special purpose of undertaking *basic* research should at all costs avoid acceptance of responsibility for routine work of any kind. The existing Central Research Institute at Kasauli has now become little more than a centre for the manufacture of biological products and it is recommended that work of this kind should continue to be carried out at this Institute together with applied research in relation to this primary function and certain other routine functions, which will be considered more fully below.

19. The existing institutes and laboratories in the Provinces also have heavy routine duties to perform and these are likely to increase in the future. In the Presidencies of Madras and Bombay, the scope and functions of the King Institute and the Haffkine Institute respectively have increased progressively over the past forty years. The stage has now been reached in both of these Presidencies when there is an urgent need for decentralization of some of the functions of the main institutes by establishing regional laboratories at selected centres. These laboratories should be affiliated to the parent institute and should undertake only those functions which it is desired to decentralize as for example, diagnostic laboratory work for hospitals and practitioners, and public health laboratory work such as the examination of water, foodstuffs, etc., as required by the public health services. Other functions such as the manufacture of biological products should continue to be the responsibility of the parent institute. The accommodation and facilities available in the existing institutes should be improved and expanded to permit of the conduct of research work on a larger scale than is at present possible, and to allow of the training of personnel in routine and research methods. Regional laboratories should be planned to allow for expansion of the routine duties allotted to them and to provide sufficient accommodation and equipment to enable them to undertake research, especially research of a clinical nature. A more detailed consideration of the future of the existing and proposed laboratories in the Presidencies of Madras and Bombay will be given in later sections of this report.

20. In some Provinces, existing institutes and laboratories are inadequate for present day needs and in some there is little or no provision for work of this kind. In Bengal, for example, the Government has made provision for the conduct of routine public health laboratory work and for the manufacture of essential biological products in piecemeal fashion. The existing laboratories are considered to be totally inadequate for the needs of the Province, and we

recommend the creation of an Institute of Preventive Medicine in Bengal on the lines proposed for the future development of the King Institute, Guindy or the Haffkine Institute, Bombay. In addition to a new institute of this kind, adequately staffed, constructed and equipped on modern lines, the creation of subsidiary regional laboratories at selected centres throughout the Province is recommended.

21. In other Provinces, such as the Punjab and the United Provinces, provision for public health laboratory work, clinical diagnostic work and the manufacture of essential biological products are barely sufficient for present-day needs, and we recommend that the existing public health laboratories in these Provinces should be improved and expanded on the lines indicated above, and ultimately de-centralized in a manner similar to that proposed for Madras and Bombay. In those Provinces and Indian States where few, if any, facilities at present exist for work of this kind, new institutes will be required.

22. One of the primary functions of the main institutes in the Provinces, whether existing or proposed, will be to undertake the large-scale manufacture of primary public health requirements of vaccines, sera and other biological products. This does not mean that Government laboratories need come into competition with commercial firms already engaged in the large scale manufacture of biologicals, since the latter are engaged chiefly in the preparation of products required by hospitals and practitioners throughout the country rather than those of primary public health importance such as prophylactic vaccines, vaccine lymph, etc.

23. We recognise that the manufacture of biological products by commercial firms in India is an industry which is now well-established and one which, at the present time, is making rapid progress. There are already numerous firms in Bengal, Bombay, the Punjab and Kashmir. As a rule, the manufacture of biological preparations is undertaken by firms engaged also in the manufacture of other products such as pharmaceutical preparations. We also recognise that some of the leading commercial firms in India have already made great strides towards the production of biological preparations under more satisfactory conditions than was formerly the case. Two of us (Drs. Vishwanath and Butt) are of the opinion that the time has now arrived when the manufacture of such products should be a responsibility of commercial firms under sufficiently strict Government inspection to ensure public safety. The others, while taking due note of recent developments in the manufacture of these biological products by commercial firms, consider that the interests of the people should come first so far as essential medical requirements, including such biologicals, are concerned. The large scale production of basic prophylactic preparations, such as cholera, plague, T. A. B. vaccines, vaccine lymph and antirabic vaccine is of paramount importance to public health authorities in India in protecting the people against epidemics. It is therefore considered that their production should remain a Government responsibility. So far as the requirements of these products of non-governmental agencies are concerned, Governments should make these products available at cost price or even below the cost of manufacture, where necessary.

The views of our colleagues on this and certain other points are set out in a note which is appended to this chapter.

24. The following specific recommendations are made in regard to the existing Central and Provincial Government laboratories:

**Organizations Financed by the Central Government**

25. (a) *The Central Research Institute, Kasauli.*—This institute was originally designed to fulfil the functions which its name implies but it has been compelled to accept the responsibility for an ever-increasing volume of routine work, particularly the large-scale production of vaccines and sera. Nevertheless, a large amount of important research work has been carried out at the Institute, some of it having a direct bearing on improved methods and procedures for the manufacture of biological products. We recognize the need for a model biological station maintained by the Central Government and we consider that the existing Institute at Kasauli would, with certain modifications and extensions, provide a suitable location for such a station, the primary functions of which would be (1) to manufacture a representative series of biological preparations under optimum conditions so as to provide an ideal standard for the trade; (2) to carry out applied research, particularly in regard to the evolution of newer and better products and of improved methods for their preparation; and (3) to provide a training centre for expert technical personnel in work of this kind. We consider that Government cannot reasonably enforce the provisions of the Drugs Act (1940) and demand a standard of manufacture by commercial concerns which they themselves cannot demonstrate. In addition to the routine functions at present being performed by the Institute and those proposed above, provision should also be made at the Institute for a permanent Serum Standardization Section.

26. The present buildings and equipment of the Institute at Kasauli are in most respects satisfactory for the work in progress but there are certain serious defects which would require to be rectified before the Institute could become a model biological station with facilities for applied research. Apart from the many facilities already available at Kasauli, the climate is ideally suited for breeding and maintaining animals under very favourable conditions. The Kasauli Institute possesses a fine library and would make an ideal centre to which research workers from the plains could recess during the hot weather for the purpose of preparing reports, papers for publication, etc.

It is suggested that the name of the institution be changed into the Central Biological Products Laboratory.

27. (b) *The Malaria Institute of India.*—Recommendations as to the future role of this Institute are given in the section of this report which deals with researches on special subjects.

28. (c) *The Biochemical Standardization Laboratory.*—This laboratory forms the nucleus of the proposed new Central Drugs Laboratory. We recommend that the latter should be constituted at the earliest possible date. We recommend that provision should be made in the new Central Drugs Laboratory for the conduct of research of an applied nature relating to the evolution of newer and better methods of assay.

**Organizations Financed by Provincial Governments**

29. The survey of existing institutes and laboratories given in Vol. I of this report shows that some of these are good (e.g., King

Institute, Madras and Haffkine Institute, Bombay); some are barely sufficient for present needs (*e.g.*, the laboratories in the United Provinces and Punjab); some are poor (*e.g.*, the laboratories in Calcutta) and that in some Provinces none exist at all. We recognize the value of well-developed institutes of preventive medicine in relation to public health work in the Provinces and emphasise the need for at least one modern, well-equipped and adequately staffed institute of this kind in each Province in the first instance. As progress is made, it will be necessary to create additional institutes and laboratories at other centres throughout each Province so as to de-centralize most of the functions of the parent institute. Proposals on these lines have been put forward by the Directors of the King Institute and the Haffkine Institute for the Presidencies of Madras and Bombay respectively, and so far as they go these proposals have our full support. It is felt, however, that these proposals represent an immediate necessity and that even if they were implemented in full, the end-point in the provision of laboratory and research facilities would not have been reached. We are not, however, in a position at present to make specific proposals for further development. With the rapid expansion of health services contemplated under our health programme, the need for laboratory services will naturally increase. At the same time the medical teaching centres contemplated under our scheme, the district headquarter organisations and even the secondary health units may be expected to provide laboratory facilities of different degrees of efficiency. Further, in regard to special branches of medicine, laboratory and research facilities will be developed in different provincial postgraduate training centres we have recommended. In these circumstances we must leave it to the provincial health authorities to plan the development of such further laboratory and research facilities as may be required in the light of the arrangements which will come into existence as the result of the proposals we have already made.

30. The proposals for the development of an improved laboratory service for Madras Presidency, which will be described in some detail below, set a standard which other Provinces would do well to follow both as regards the functions of the regional laboratories and as regards the organisation of the Central Provincial Institutes. Similar proposals have been made for the Bombay Presidency. We would suggest that, for reasons already stated, this scheme of regional laboratories should be linked with other developments in connection with our health programme.

31. *The Madras scheme.*—We recommend the continuance, on an extended scale, of the functions hitherto carried out by the King Institute, and endorse the proposals outlined by the Director of the Institute for the re-organization of the Institute itself and for the development of daughter regional laboratories to be established throughout the Presidency. These proposals are briefly summarized below:—

32. *The creation of regional laboratories.*—There is an urgent need to de-centralize some of the functions of the King Institute so that laboratory service may be more readily and more widely available in the districts than is the case at present. Hitherto, the King Institute has served as the laboratory for most of the district headquarters

hospitals but, owing to the limited amount of clinical material which it has been possible to send to the Institute for examination, the hospitals have not had as complete a laboratory service as they require. In addition, health workers in the field, especially during epidemics, cannot at present obtain adequate laboratory service near at hand. For these reasons the creation of regional laboratories at the following centres is necessary :—

- (1) Bellary—to serve the needs of the Ceded districts.
- (2) Madura—to serve the Southern districts.
- (3) Coimbatore—to serve Salem and the West Coast districts.
- (4) Vizagapatam—to serve the Northern Circars.

The last-named could conveniently be established in connection with the Medical College at Vizagapatam and, if medical colleges are established in the other places also, the regional laboratories should be associated with them. Other districts such as Nellore, North Arcot, South Arcot, Chingleput, and Madras City would continue to be served by the parent institute at Guindy, while the Pasteur Institute, Coonoor would continue to serve the Nilgiris and surrounding areas.

33. The functions proposed for these regional laboratories include the conduct, for their respective areas, of the following :—

- (1) Bacteriological and serological examinations of all clinical material received from hospitals and dispensaries and from the public health authorities.
- (2) Examination of samples of food submitted in connection with the Prevention of Adulteration Act.
- (3) Examination of water from protected supplies in the area.

Regional laboratories would also serve as subsidiary centres for the distribution of biological products, such as therapeutic sera and prophylactic vaccines. In addition, the regional laboratories would be well-placed for development as centres of research, particularly clinical research for which a wealth of material would be available from the well-equipped district hospitals. Decentralization on the lines recommended would ensure more efficient and more widespread diagnoses of disease and better investigation and control of communicable diseases. There would also be provision for the extension of the important functions of food and water analyses, thus providing for an extension of food and water control to the remoter areas. Regional and district laboratories, when formed, should be placed under the administrative control of the Director of the parent Institute at Guindy. A cadre of especially selected and trained officers and assistants should be maintained to serve the King Institute as well as the regional and other laboratories in the Presidency. Similarly, common provision should be made for the supply of all laboratory materials, stores and equipment.

34. *Re-organization of the King Institute.*—It is not anticipated that, when some of the functions of the King Institute have been de-centralized in the manner outlined above, the work of the parent institute will be decreased. On the contrary, it will be extended and developed, especially for research purposes, and this will necessitate

a re-organization of the existing sections and the provision of additional accommodation and equipment. The Director's proposals for re-organisation of the Institute, with which we fully concur are summarised below :—

(1) *Diagnostic Department.*—For the examination of clinical material, the preparation of diagnostic reagents and their issue to all regional and other laboratories in the Presidency, and the maintenance of stock cultures.

(2) *Department for the Manufacture of Bacterial Vaccines, Sterile Solutions, etc.*—The work of this department would be carried out in a new block especially designed and built for the purpose.

(3) *Vaccine Lymph Department.*—This department would remain, as at present, a centre for the manufacture, storage and distribution of vaccine lymph.

(4) *Department of Anti-toxins.*—This department would produce therapeutic sera for the Presidency and also products for immunization against diphtheria, tetanus, etc.

(5) *Government Analyst's Department.*—This department would carry out duties similar to those at present undertaken for the areas under its jurisdiction and would be available as a reference laboratory for the new regional laboratories.

(6) *Department of Water Analysis and Algal Control.*—This department would assume responsibility for the chemical and bacteriological analyses of water and undertake research work on the control of algal growth in water-supplies and on water purification.

(7) *Department of Medical Bacteriology.*—This department would assume responsibility for the conduct of laboratory work on malaria, filariasis, dracontiasis, medical entomology, helminthology, etc. Field investigations in connection with these diseases would be carried out by the "Investigation Units" already established for the purpose.

(8) *Blood Bank Section.*—This section would function mainly as a blood processing centre if the policy of establishing blood banks (whole blood) in the Presidency is adopted. It would also serve as a centre for research in the development of better methods of processing and drying.

When the Institute has been re-organized on the above lines and when additional staff, accommodation and equipment have been made available, it will be possible to continue and expand research activity in the various departments. The Institute is at present better staffed and equipped for research on filterable viruses than any other in India and is likely to maintain its premier position in this field of work.

The good library facilities at present available will be further developed in order to provide a comprehensive medical library for South India, the amenities of which will be available to workers in other medical institutions and to private practitioners.

35. *Haffkine Institute, Bombay.*—The Haffkine Institute, Bombay, has made rapid advances during the past decade and may now be considered one of the best equipped and most active laboratories in India for routine and research work of the type undertaken. At the present time work is in progress to extend the laboratory accommodation at a cost of approximately Rs. 12 lakhs in order to set up new departments.



36. Plans for future development now being discussed include the provision of an adequate laboratory service for the Presidency by the creation of four regional laboratories at Belgaum, Poona, Nasik and Ahmedabad, and by the provision of improved laboratory services at each district hospital throughout the Presidency. The intention is that these greatly extended laboratory services will undertake work both for hospitals and for the Public Health Department. These proposals are, therefore, very similar to those outlined for Madras Presidency.

37. In order to increase the supply of highly-trained laboratory technicians in the Province to keep pace with the expansion outlined above, a scheme is at present being initiated under which the Haffkine Institute will recruit 12 science graduates each year to undergo a course of training in bacteriology and clinical pathology, lasting for 12 to 18 months. The aim will be to train 70 to 80 men of this type for posts in the extended laboratory service of the Province.

38. We recommend the continuance of the routine and research functions at present being performed by the Haffkine Institute and endorse the proposals for their future development and extension. We also recommend that the plans for establishing regional laboratories throughout the Province and for improving laboratory facilities at each district hospital should be carried out.

39. (c) *Laboratories maintained by the Government of Bengal.*—The provision at present made by the Government of Bengal for the conduct of public health laboratory work, particularly for the preparation of essential biologicals, is quite unsatisfactory. There is a very real and urgent need in Bengal for a properly constructed, staffed and equipped Institute of Preventive Medicine organized on the lines proposed for the future development of the King Institute, Guindy, or the Haffkine Institute, Bombay. We consider that such an institute could be conveniently located on the outskirts of Calcutta where building sites can be obtained at cheaper rates and on a more extensive scale than in the urban area. The chief functions of the institute recommended would be:—

- (1) The conduct of public health laboratory work of all kinds, including departments for food and water analyses, diagnosis, medical biology, etc.
- (2) The preparation, under optimum conditions, of a representative series of biological products, including departments for the large-scale preparation of bacterial vaccines, anti-rabic vaccine, anti-toxins, prophylactic toxoids, vaccine lymph, sterile solutions for parenteral injection, etc.
- (3) To provide accommodation for the Provincial Drugs Control Laboratory.
- (4) To provide a training ground for expert technical personnel.
- (5) To carry out applied research in relation to all branches of the routine work of the institute.

40. An institute of this kind would undoubtedly be a great asset to the Province, but it is probable that, with greatly increased emphasis

on public health activities of all kinds, it would soon become necessary to establish subsidiary laboratories, especially for public health and diagnostic work, at other centres throughout the Presidency. These might conveniently be established on lines similar to those proposed for regional laboratories in Madras Presidency. One of the most important functions of the main institute would be to form a modern biological station so as to set a high standard for the various commercial firms already established in Calcutta, and to provide a training ground for expert technical personnel to be employed by them.

41. The new institute should be established on bold lines and should be constructed and equipped in such a manner that it could be adapted to altered functions or new lines of work, without incurring extensive structural alterations. The functions of any institute of this kind are continually changing and developing in relation to up-to-date knowledge and no greater mistake can be made than to build and equip an institute with regard only to its immediate requirements.

42. *Laboratory Services in other Provinces.*—We recommend the progressive development in all other provinces in India of laboratory services and facilities for research similar to those outlined above for the three Presidencies of India.

#### **Organizations Financed from Other Sources**

43. *Pasteur Institute of South India, Coonoor.*—This institute is capable of being developed into an active centre for medical research. So far as they go the laboratories and equipment are good, but any great extension of work requires the provision of additional laboratories. The institute is exceptionally well-provided with facilities for the breeding and maintenance of laboratory animals.

44. The Association of the Pasteur Institute of South India is the only remaining "Pasteur" organization in India which is self-supporting and, therefore, inherits a claim to become the chief centre for rabies research in India. It is recommended that it should be developed as such, and that it should receive additional support from other sources such as the proposed Central Medical Research Organization or the income on the invested capital of the Association of the Pasteur Institute of India. Rabies research has been neglected in recent years although there is still a great need for it. For example, the anti-rabic vaccine at present in use is identical with that introduced by Semple at Kasauli in 1911, which must be regarded as an extremely crude product. Preliminary work carried out at the Pasteur Institute, Coonoor, a few years ago has shown that it is possible experimentally to eliminate much of the animal protein from sheep-brain vaccine without impairing its antigenic value. It is obviously important that this work should be followed up especially as there are indications that the rare, but highly dangerous, complication known as "paralytic accident" may be due to the brain protein included in the present crude vaccine. The aetiology of "paralytic accident" is another problem which deserves further investigation. Likewise, there is room for further research to evolve better and more certain methods for the diagnosis of rabies in animals. These and other unsolved problems in regard to the diagnosis and prevention of rabies necessitate the setting up of at least one active centre for

rabies research in India and, in our opinion, the Pasteur Institute at Coonoor offers an ideal location for such a centre. It would, of course, be necessary to increase the staff of the Institute, to provide the necessary equipment for the work to be undertaken, and possibly even to extend the available laboratory accommodation. Rabies is very prevalent both in jackals and dogs in the Nilgiris and no difficulty would be experienced in obtaining strains of "street" virus for experimental work.

45. The Institute at Coonoor is already well equipped to undertake laboratory diagnostic work for hospitals and practitioners and it could, therefore, be readily converted to undertake the functions of a regional laboratory for the Nilgiris area in the scheme recommended for the Madras Presidency (see recommendations under King Institute, Guindy).

46. The continuance in Coonoor of the Nutrition Research Laboratories as a nutrition centre for South India, and of the South India branch of the Malaria Institute of India already in Coonoor is recommended. If these various interests were properly coordinated, the Pasteur Institute would become a very active centre for research on such important subjects as rabies, nutrition and malaria. The easy accessibility of all parts of South India from Coonoor and the enormous amount of material available in or near Coonoor, make it ideally suited for development as a research centre for these subjects.

47. *Miscellaneous.*—The potentialities of other institutions in the future development of medical research in India will be apparent from the review of the resources of individual organizations given in the first volume of this report.

## V. Researches on Special Subjects

48. Certain special subjects, particularly malaria and nutrition, are of such paramount importance to all sections of the community in India that research on them is required on an exceptionally wide scale.

49. *Malaria.*—While it is recognized that there is still need for further research of a basic nature on many aspects of the malaria problem in India, knowledge of this disease has advanced so far that the bulk of the research work now necessary on this subject is so intimately integrated with practical malaria control measures that the two cannot be dissociated. The organization required for practical malaria control measures and research activities associated with them is primarily of a public health character and must be so regarded and financed by the Central and Provincial Governments. The following minimum organization is considered to be essential:—

(a) *The Malaria Institute of India.*—This organization, originally constituted and financed by the Indian Research Fund Association, has already been taken over in part by the Central Government, and now functions as a public health organization financed from Central Revenues. The existing organization has been properly conceived, but requires to be greatly expanded in order properly to fulfil the functions enumerated for this Institute in the section dealing with our recommendations in respect of malaria.

The research activities of the Institute are, at present, financed by the Indian Research Fund Association but there is great need for

the extension of these activities. Research activities must remain a primary function of this Institute, especially research of an applied nature, while research of a basic nature should be carried out in association with the appropriate sections of other organizations such as the proposed new All-India Medical Institute and Chairs of Malariology in Medical Colleges. There are many aspects of the malaria problem which can best be investigated in this way, for example, the study of biological, clinical, biochemical and pharmacological problems.

The Malaria Institute of India must maintain its position as the chief information bureau on malaria in India, and the Director and staff of the Institute must keep themselves fully informed of all advances in knowledge made in other parts of the country and of the world. Delhi is considered to be a suitable location for the present Institute, but it is desirable that the branch of the Institute established at Coonoor in S. India should be retained and expanded.

The Malaria Institute has done much to spread knowledge of this disease throughout India particularly by training medical officers from all parts of the country in malariology, and also engineers in the principles and practice of malaria prevention. Apart from this we have included the suggestion, in our special recommendations in respect of malaria, that Chairs of Malariology should be established in selected medical colleges in the Provinces in order to provide further facilities for teaching and research in the subject.

(b) *Provincial Malaria Organizations.*—There is an urgent need in each Province in India for a strong malaria organization to plan and execute malaria control schemes and to conduct the preliminary and concomitant investigations which are invariably necessary in connection with them. We have made detailed recommendations for the establishment and maintenance of such provincial organisations in the chapter on malaria.

The wealth of clinical material available for study at all medical teaching and relief centres throughout the country should be utilised for the conduct of special investigations on the clinical and therapeutic aspects of malaria.

50. *Nutrition.*—Nutrition is a problem of vital concern to the people of India. Active research is a necessary part of any successful attack on the nutrition problem. All progress is based on research and there is abundant evidence to show that nutrition research can make valuable contributions to human welfare. In all progressive countries, large sums are spent on nutrition research and it is necessary that, in India also, such research should receive ample encouragement and support in order to hasten the solution of short and long-term policies regarding nutrition.

51. The Nutrition Research Laboratories at Coonoor were founded by the Indian Research Fund Association in order to provide a strong centre for research on nutrition problems; to act as an information bureau so as to make the results freely available to all concerned; and, in collaboration with public health officers, to translate these results into practical nutrition work. We recognize the important work already carried out by this organization and recommend that the Coonoor laboratories should be retained as a nutrition centre for

South India. We consider, however, that extended provision for the study of nutrition in India both in its laboratory and public health aspects, is necessary. Experience has shown that the Central Government has been unable to make the fullest use of the Coonoor laboratories on account of their great distance from the Capital. The creation of a strong central nutrition organization with staff and laboratories adequate to form a permanent centre for research, reference, advisory and advanced training work, is recommended. This might conveniently be included as a section of the proposed new All-India Medical Institute.

52. Apart from this provision for nutrition research at the centre, there is a great need for widespread research to be carried out in the universities, medical colleges and other laboratories in the country. In addition, the great mass of clinical material available in India provides an opportunity for India to lead the world in clinical research on nutrition. We recommend the development of clinical research units to be attached to some of the larger hospitals in India, and, in particular, to hospitals for children's and ophthalmic diseases. Non-medical workers, such as biochemists, could play a valuable part in the work of such units.

53. In our view the present system of supporting nutrition research by temporary year-to-year grants to individual workers has certain disadvantages, including interruption in the continuity of work and the frequent loss of the services of workers who have gained some experience. We recommend that this system should be largely replaced by the support of nutrition research units of a more permanent nature at selected places where suitable laboratories exist together with a nucleus of experienced workers and competent direction. This would ensure continuity of work and provide opportunities for the training of skilled nutrition workers as well as for the development of national nutrition organizations. The two such units recently established at Bombay and Dacca should be further developed.

54. We consider that the translation of the results of research to practical public health measures is an essential function of the Health Departments of the Central and Provincial Governments. We have therefore made proposals for the creation, as a part of the health organisation, of nutrition departments at the Centre and in each Province, in that chapter of this report which deals with our recommendations regarding nutrition. For the composition and functions of these nutrition departments reference may be made to that chapter.

55. We recognize the necessity for training all medical and public health workers in nutrition, and to this end we recommend that satisfactory instruction in the subject be included in all training programmes including the medical curriculum and the courses given to health visitors, health inspectors, etc.

56. *Clinical Research.*—In spite of the great wealth of clinical material available in India, very little clinical research of high quality has hitherto been undertaken. An exception to this rule is the research work carried out at the Calcutta School of Tropical Medicine with which the Carmichael Hospital for Tropical Diseases is associated. A similar successful arrangement for clinical research has been provided at the Pasteur Institute, Shillong, to which a small Clinical Research Hospital is attached. The hospital attached to the

medical college, which will form an integral part of the proposed All-India Medical Institute, will also facilitate the promotion of clinical research. Nevertheless, it will be necessary, in our opinion, to create facilities for clinical research in many other centres throughout India. There are already many well-equipped hospitals with abundant clinical material in which research work could be undertaken. The primary requirements in stimulating such activity is the provision of adequate personnel of the right type. In most instances it would be necessary to provide additional laboratory accommodation, equipment and experimental animals. It would be necessary to engage workers specifically for wholetime research work. If this practice were followed in all teaching hospitals in India, present and future, a field for clinical research would be opened up which would probably be unsurpassed in any other country in the world. In many cases the conduct of clinical research would require the close cooperation of the preclinical and technical departments of the teaching institutions. To facilitate team work of this kind, it would be desirable to appoint for each teaching institution a Director or coordinator of research. Apart from clinical research in teaching hospitals, further opportunities are likely to be provided in connection with the extension of laboratory services in the Provinces, as, for example, at the regional laboratories proposed for the Presidencies of Madras and Bombay, which it is anticipated will be intimately connected with well-equipped district headquarters hospitals. We recommend that these and all other facilities for clinical research should be exploited to the fullest extent. It is visualized that if clinical research is encouraged in the ways indicated, centres of high repute for research and advanced teaching in clinical medicine and surgery and the various specialities will spring up throughout the country. Potentialities for the creation of such centres already exist as, for example, the Orthopaedic Surgery Unit in Madras and the Radium Therapy Unit at the Tata Memorial Hospital, Bombay.

57. *Social and Environmental Factors in relation to Health and Disease.*—We recognize that many of the recommendations made in this report for the future extension and development of medical research in India relate chiefly to research activities in medical colleges, hospitals, and other institutions. While "institutional" research of this kind is of the greatest value, there is a danger of its becoming so specialized and technical that the primary importance of the many indefinite factors of aetiological and human interest in relation to the ill-health of the country may tend to be overlooked. During the past two or three decades, medical research all over the world has tended to become "mechanized" and there has been an insufficient appreciation of the fact that ill-health, even that due to many of the organic diseases, has discoverable origins in a complexity of environmental factors including social, domestic and occupational maladjustments associated with economic insecurity, dietary insufficiency, over-fatigue and a host of other related factors. Social and environmental factors in relation to health and disease are of particular importance in India, not only as regards the study of human reactions to them but also as regards their influence on the vectors of insect-borne diseases.

58. Little is as yet known of health itself within the considerable ranges of age, sex and occupation or of the manifestations and

standards which distinguish the individual in full health from the individual with incipient illness, perhaps not yet demonstrable by known methods of detection. Likewise, little is known of the environmental factors which favour the spread of such insect-borne diseases as malaria, plague, kala-azar, the typhus group of fevers, etc. There is in India an inexhaustible field for the investigation of these and many other problems related to social diseases and disability, and for the study of man during growth and development and his reactions to environmental stress. There is much to be learned too, from the periodical study of healthy groups in childhood, adolescence and later life.

59. This approach to the investigation of ill-health is not a new concept but it is one which has been brought sharply into focus in other countries as the result of the war, and one which, it is hoped will persist in the post-war period. The success which has attended the practical application of the results of research on this important subject has been amply demonstrated among the peoples of Western countries under the duress of war and has resulted in a re-orientation of outlook on disease in these countries.

60. We, therefore, recommend that in planning the future development of medical research in India, adequate provision should be made for research on this important subject. It is felt that research on this aspect of health and disease must follow a definite plan. The first essential will be to collect statistical and other data relating to the possible aetiology of the problem under consideration. Subsequent analyses of such data would be likely to give some indication of the probable causes of high disease rates. It would then be necessary to undertake a close study of individual cases of the disease in question with special reference to environmental history. Any environmental factor under suspicion would have to be further investigated by making a survey of an adequate population sample exposed to the suspected aetiological factor together with a parallel survey of a comparable group not so exposed. The next logical step would be an attempt to reproduce the conditions in experimental animals and, finally, it would be necessary to prove or disprove the hypothesis by modifying the environment of an exposed group by removing or neutralizing the suspected adverse factor or factors and observing the effect on the incidence of the disease in question.

61. Investigations on the lines suggested above would obviously be beyond the competence of isolated individual workers and would have to be undertaken by comprehensive research teams requiring the closest collaboration and cooperation between public health officers, hospital clinicians and private physicians, statisticians, nutrition and other research workers, sanitary inspectors, health visitors, social workers, and even local lay bodies. The onus of unearthing and exposing social and environmental evils in the aetiology of ill-health must rest with the medical profession and their scientific associates. The laborious task of collecting and analysing statistical data and of recording factual evidence and socio-medical experience must be borne largely by those whose concern is with the social rather than the individual aspects of disease and, in order that they may be able to fulfil this function, they must be guided by teaching and research in social medicine. The scope of this subject is so vast that

it could not be adequately dealt with by a special branch, but must become an integral part of all medical and social activities. In preparation for this, the importance of the subject must be stressed at all stages of the medical curriculum.

62. There is an increasing tendency for medical subjects to be grouped in the form of a "Y", the stem of which represents subjects common to all fields, while one arm represents the subjects dealing mainly with *individuals*, and the other the subjects pertaining to groups of *individuals* or communities. Research of the kind here visualised would be centred mainly, though by no means exclusively, in those departments concerned chiefly with *community* studies in both urban and rural areas. The development and strengthening of these departments would, therefore, be a primary necessity in fostering research in social and environmental factors in relation to health and disease. The field to be covered would, however, be so comprehensive that it would be necessary to appoint specially selected workers to initiate, stimulate and, above all, coordinate research on this important aspect of human welfare.

### Conclusion

We wish again to emphasize that, for the effective extension and development of medical research in India, greatly increased and improved provision for training on a higher standard in the universities and medical colleges is essential at all stages, and that, in order to achieve this, existing institutions will require improvements and additions to their accommodation and equipment and to their academic staff, while many more training centres will be required. The employment of wholetime teachers and research workers on scales of pay adequate to attract the very best men will all occasion an enormous increase in expenditure, but this must be regarded as unavoidable if any real progress is to be made.

### A Note on Medical Research by Dr. Vishwanath and Dr. A. H. Butt

64. Apart from paucity of funds the worst enemy of the progress of medical research in India has been the fact that the officers employed in the Medical Research Department, were mostly engaged in the manufacture of biological products and had very little, if any, time to devote to their declared function—Medical Research. A stage of development has now been reached in the country when the manufacture of biological products should be a purely Government's function, if the State is worked on a socialistic basis. If its organisation is capitalistic, the manufacture of biologicals should be in the hands of the trade but under proper Government supervision. The existing conditions under which Government is in competition with trade is unjustified, particularly when it deflects personnel which should be serving the advancement of medical research, to routine manufacture.

65. One important channel of financing medical research in India has been a quasi-Government organisation—The Indian Research Fund Association. In our opinion the financing of medical research could be aided effectively and expeditiously by a progressive Government. The argument of less red-tape in the working of a quasi-Government organisation is offset by greater scope for nepotism under such an organisation.



## CHAPTER XX

### ALL INDIA MEDICAL INSTITUTE

#### Introduction

1. At an early stage in our examination of the problem of developing a comprehensive health service in India we realised that certain outstanding needs must be met before any progress in the provision of such a service could be made. These include (1) a considerable expansion of existing facilities for the training of doctors and other health workers in order to produce the large numbers that will be required for our scheme, (2) a revision of the standards of professional training in order to produce types of workers fully equipped to participate in a modern health programme with its newer and expanding conceptions of service to the community and (3) the training of a sufficient number of workers capable of undertaking research into medical and allied problems on a scale far in advance of what has been accomplished in the past. In that section of the report which deals with professional education we have discussed, at some length, our proposals for increasing the numbers of institutions required for training the different types of health personnel and for improving their education in accordance with modern trends. We have also advocated the provision of facilities for research by all the departments of these institutions, because we feel that undergraduate and postgraduate teaching of the requisite standard can be attained only in an atmosphere of active research.

2. These institutions will naturally have to concentrate on the production, in as large numbers as possible, of the different types of health workers required for the health services we have proposed. Side by side with these developments, however, we consider it of the first importance that at least a few institutions, which will concentrate on quality, should also be established at suitable centres in different parts of the country. We realise that considerations of cost and the need to staff these institutions with the most highly qualified persons available will, in all probability, make it very difficult to start with more than one such training centre. But no time should be lost in developing one such centre for which we would suggest the designation "All-India Medical Institute." The objects of the Institute should be:—

- (1) to bring together in one place educational facilities of the highest order for the training of all the more important types of health personnel and to emphasise the close interrelation existing between the different branches of professional education in the field of health;
- (2) to promote research of the highest type in all the branches of study for which the Institute will be responsible;
- (3) to coordinate training and research;
- (4) to provide postgraduate training of an advanced character in an atmosphere which will foster the true scientific outlook and a spirit of initiative and
- (5) to inspire all persons who undergo training, undergraduate or postgraduate, with the loftiest ideals of the profession to which they belong and to promote in them a community outlook and a high degree of culture, in order that they

may become active apostles of the progressive spirit in whatever field they may be called upon to serve, whether it be teaching, research, general health work or administration.

Though the *alumni* of such an Institute may not be numerous, we feel confident that the influence which they will exert in their respective spheres will be out of all proportion to their numbers.

In no field of medical work is the need for men and women of the highest training and equipment greater than in that of teaching. We look forward to the Institute sending forth such workers, even though it may be in relatively small numbers, to the teaching institutions in different parts of the country, where we anticipate they will help to create and maintain something of the high ideals of teaching and research with which the Institute will have inspired them. Apart from such contribution to the development of professional education in the country which the Institute will make, we believe that, in view of the present shortage of highly qualified teachers, it may be advisable to include, within the functions of the Institute, the training of a limited number of selected individuals from the provinces, so that the facilities for advanced training available at the Institute may be extended as widely as possible without sacrificing efficiency in any way. It is hoped that the Institute will attract to itself candidates from among the most talented products of the provincial medical colleges, who in due course will return to their *alma mater*, there to disseminate the ideas and ideals acquired by them at the Institute.

### **The Range of the Institute's Activity**

3. We suggest that, in the beginning, the Institute should aim at providing only medical training in all its branches and also the training of nurses. The Institute must, therefore, have as an integral part of it, a medical college with its teaching hospitals and laboratories as well as a college to provide the highest type of nursing education. Later on, provision should be made for the training of all higher types of health workers. We have in mind particularly dental education, public health engineering, medical zoology in its different branches and certain other subjects in which the non-medical man performs important health functions.

4. We believe that the contribution which the proposed Institute can make to promote the cultural value of medical education will be greatly enhanced by the provision of a Chair of the History of Medicine. The humanising influence of a study of the history of medicine has been well described by Professor Henry E. Sigerist in a recent publication (Appendix 47).

He says:

"Instruction in medical history, if properly conducted, could greatly contribute to the training of an educated physician. It would teach the student history, the history of his own country but also the history of the world with a bias on medicine that would bring the subject much closer to him. It would teach him to look at modern medicine from the perspective of history and to see it in all its economic, social, religious and philosophic implications, as the result of a long development, as a dynamic process. He would soon find that scientific medicine has a philosophy also. We too look at the human body as a microcosm in the midst of the macrocosm. The same elements

that constitute the organism are found in the outside world, and the same physico-chemical forces are acting in both. The physician thus trained would have a much clearer idea of the task of medicine and of the part he is called upon to play in society."

We fully endorse his view that the physician of the future should be an even more highly cultured individual than his predecessors and that he should have, to a greater extent, that wider outlook which will enable him to interpret health and disease in relation to the social background of the life of the community. In this country, we believe that the historian of medicine can also perform the eminently useful function of investigating the indigenous systems of medicine "not only for their ideological content, not only as aspects of India's ancient and mediaeval civilisations and as end products of a long development" but also for the purpose of assisting in the evaluation of their practical achievements. As a result of his studies, he may be in a position to point out to the clinicians and pharmacologists which drugs and treatments employed in these systems can be tested.

#### **The Selection of Students**

5. The selection of students to be admitted to the medical and nursing colleges attached to the Institute should be made very carefully, merit being the sole criterion for admission. The purpose in view is that the men and women passing out from these colleges should provide future leaders in their respective professions and, in our view, the acceptance of any basis of selection other than merit will defeat this purpose. As the Institute is to serve the needs of the country as a whole, applicants from all parts of India should be eligible for admission.

#### **Certain Qualifications for the Staff of the Institute**

6. We have already expressed the view that the endeavour should be to inspire all, who undergo training in the Institute, with the highest ideals of the profession to which they belong and to develop in them a community outlook and a high degree of culture. The teacher must himself be imbued with these ideals if he is to impart them to his students. We wish to emphasise that the men and women, who are recruited to the teaching staff of the different departments of the Institute, should possess, in addition to high intellectual and academic attainments, such ideals in a pre-eminent degree so that they may help, in their daily contacts with their students, to enrich the minds of the latter not only with knowledge but also with that deeper understanding of human nature and the spirit of service which are essential for enabling health workers to give of their best to the community.

7. We are confident that the Institute, if developed on proper lines, will profoundly influence medical education in India in the same manner in which the establishment of the Johns Hopkins Medical School at Baltimore in the United States more than 50 years ago had a powerful stimulating effect on the development of medical education in that country. The founders of that school set new standards for America by blending the best elements in the different educational systems in Europe and by introducing new ideas. Men, who passed out from the Johns Hopkins School, gradually spread

through the country and carried with them the traditions of that institution. The example of that school was widely accepted, and the result was that the standard of medical education was raised in the United States as a whole. We look forward to similar beneficial results following in India from the establishment of the proposed Institute.

Beyond indicating what, in our view, should be the objectives to be attained by this Institute we do not propose to go into any details apart from dealing briefly with its general organisation and control.

We recommend that the Central Government should be responsible for the establishment and maintenance of this Institute.

### Organisation and Control of the All-India Medical Institute

8. The organisation and control of the Institute cover (1) the administrative field and (2) the technical and scientific field. We shall deal with these separately.

#### The Administrative Field

9. An institution of the type we envisage should have considerable freedom to develop its own activities independently and without the delaying and hampering effect that strict governmental control may entail. For the growth of academic freedom it is essential to ensure that the Institute should be free from the routine administrative control of a Department of Government. We, therefore, propose that its administration should be vested, from the time of its inauguration, in a Governing Body of suitable composition.

10. We suggest that the Governing Body should, in the first instance, consist of eleven members in addition to the Chairman. The latter should be an independent person, prominent in public life and outside the executive authority of the Government of India. Such a person, for instance, would be the Chief Justice of the Federal Court. The first Chairman should be appointed by the Government of India. Later, it is a matter for consideration whether the Chairman might not be appointed by the Governing Body itself. The composition suggested for the Governing Body is as follows:—

- |  |   |
|--|---|
| (1) Chairman . . . . .   | 1 |
| (2) The Vice-Chancellor of the University in whose jurisdiction the Institute is located . . . . . | 1 |
| (3) Two Vice-Chancellors from all other Universities in British India in rotation . . . . .        | 2 |
| (4) The President, Medical Council of India . . . . .  | 1 |
| (5) Another member of the Medical Council of India nominated by that Council . . . . .             | 1 |
| (6) The President of the All-India Nursing Council . . . . .                                       | 1 |
| (7) Two distinguished non-medical scientists nominated by the Inter-university Board . . . . .     | 2 |
| (8) One representative nominated by the Central Health Board . . . . .                             | 1 |
| (9) The Director General, Health Services . . . . .  | 1 |
| (10) The Director, All-India Medical Institute (Member-Secretary) . . . . .                        | 1 |

When the dental and pharmaceutical professions become developed, we suggest that the Presidents of the All-India Boards we have recommended elsewhere in this report for regulating these professions, should also be made members of the Governing Body.

The tenure of membership may be a period of three years except in the case of those who hold their seats in their official capacity.

The functions of the Governing Body will be (1) allocation of funds and (2) the laying down of general administrative policy.

### **The Technical and Scientific Field**

11. The purpose of medical education is to provide the type of doctor the community requires. If the proposed Institute is to provide, as we have indicated it should, leaders in the different fields of medicine and particularly in the spheres of professional education and research, its development should, from the very beginning be guided by sound scientific and technical advice. Although it may appear somewhat novel in this country, we suggest that the technical work of the Institute should be developed and directed not by an outside body, however eminent its members may be, which will impose its ideas on the Director and Professors of the Institute, but by the latter themselves acting as a Medical Faculty. We anticipate that those who are selected for these posts will be men and women not only with outstanding attainments in their respective subjects, but also with that wider outlook which will enable them to interpret the needs of medical education in relation to the varied responsibilities that the doctor of the future will be called upon to undertake. In making this recommendation, we are not putting forward a procedure without precedent. We understand that, in the Johns Hopkins Medical School, a similar arrangement has worked successfully for many years and that it has contributed materially to the attainment by that institution of the pre-eminent position it holds in the world of medical education. We also understand that this system generally prevails in the United States. It is, therefore, with some degree of confidence that we are recommending its adoption here in connection with the All-India Medical Institute.

### **Recruitment of the staff of the All-India Medical Institute**

12. We would draw attention to our recommendations in connection with recruitment for health services in chapter XVII of this volume of the report. The suggestions made below follow generally the principles we have laid down in that chapter.

(1) Recruitment should be solely on merit.

(2) It is essential that the best persons available should be secured. Recruitment through the world market may, therefore, have to be resorted to. The decision to do so in respect of individual posts should be preceded by a search through the country to secure suitable persons of the required calibre. The experts obtained from abroad should be entertained on short-term contracts normally not exceeding five years in the first instance.

(3) It should be made plain in the contract that every attempt should be made to train a suitable Indian within the period of the contract.

(4) There should be no reservation of any of the posts in the All-India Medical Institute for the members of any services. The criterion of selection should be merit, and reservation of posts is incompatible with this principle.

13. As regards procedure, a departure seems desirable from our general recommendation that recruitment to the different health services should be made through the various Public Service Commissions. It is essential that persons of the very highest professional standing should be secured for the posts of the Director and Professors in the different departments of the Institute. The selection should be carried out by those who are in a position to judge the technical competence of the candidates. It is also necessary that, apart from academic attainments, the persons selected should be such as are likely to work harmoniously with their colleagues and thus to ensure the smooth and successful functioning of the Institute. To secure this, we feel that the adoption of the procedure, which has been practised in the Johns Hopkins University and which, we understand, is generally followed in other universities in the United States, may with advantage be tried here. In the Johns Hopkins Medical School recommendations for the appointment of professors are made by the medical faculty of that institution, which consists of its own professors. While the authority for making the appointment is vested in the university the recommendation of the medical faculty is invariably accepted. We desire to see this principle adopted for the recruitment of the staff of the Institute, the Governing Body being the appointing authority and Medical Faculty, the recommending body.

### Salaries

14. We have already discussed the question of salaries in the chapter dealing with the organisation and inter-relationships of the central, provincial and local health administrations.

As regards persons recruited from abroad, the salaries offered will have to be such as to secure the class of persons required. They will, of course, fall outside the regular medical services of the country and, as has already been pointed out, should be regulated by short-term contracts.

The problem of recommending suitable scales of pay for Indians is by no means easy. We have discussed the different aspects of this matter in the chapter referred to above, and do not propose to traverse the ground again. We have suggested the appointment of an *ad hoc* committee by the Government of India to examine this complex and important problem, in order that suitable recommendations may be made to the Central and Provincial Governments on which they can base reasonable scales of salary for the different categories of their employees.

### Finance

15. Although we have advised that, for the reasons stated, the Central Government should divest itself of direct responsibility for the administration of the Institute, we think that it should fulfil adequately the responsibility of financing it on a sufficiently generous scale to promote its development into, and maintenance as, an All-India medical training centre on the lines indicated earlier in this chapter. An appeal should, however, be made to the public for

contributions, thus giving private generosity an opportunity to support an institution which, we feel sure, will have far-reaching influence on the future development of health service in the country. This Institute is of such paramount importance for the full development of the proposed national health programme that we would venture to suggest that its financial stability should be ensured by the Government of India endowing it with an amount sufficient to secure, through the accruing interest, at least half the estimated annual expenditure of the institution in its fully developed form and by a statutory provision for any balance that private benefactions may fail to provide.

### **Legislation**

16. Our proposals for the organisation, administration and financing of the All-India Medical Institute involve certain departures from existing practice. It, therefore, seems necessary to secure legislative sanction for these proposals.

Three of our colleagues (Mr. Sapru, Dr. Hameed and Mr. Josbi) do not agree with the rest of the Committee on a few points. Their notes are attached.

### **Minute on the All-India Medical Institute by the Hon'ble Mr. P. N. Sapru and Dr. M. A. Hameed.**

We have agreed to the suggestion that the appointment of Professors in the Department of the Central Institute for the training of teachers and research workers should be made on the recommendations of the teachers of the Institute itself, as the final selection will, we take it, vest with the Governing Body, the constitution of which will be determined by the Central Legislature. In our opinion the constitution provided for the Governing Body is reasonably good. But we cannot agree to the further suggestion that the shaping of the Institute in its technical aspect should be entrusted solely to the Director and Professors of the Institute acting as a medical faculty.

No adequate reason has, in our opinion, been given as to why on the medical faculty, which will presumably frame the curricula and appoint examiners, an external element should not be provided for. In our opinion, there is danger under a constitution of this character, of the academic faculty of the Institute developing into a close corporation of mutual admiration. We would, therefore, provide for representation on this academic body of faculties of medicine in Indian Universities, grouped together, as an electoral college for this purpose. This representation would not, however, exceed 20 per cent. of the total strength of the medical faculty. A possible alternative to this elected representation of medical faculties of universities territorially grouped together for the purposes of representation is co-option of outside experts by the medical faculty itself. We rule this solution out as we think that more harmonious co-operation between the medical faculties in various universities responsible for medical education and the Institute can be secured by their proper representation by direct election by University Medical Faculties on the academic Council of the Institute itself. It is, in our opinion, essential for the growth of higher medical education, research and

the raising of cultural levels in provincial institutions, to provide some direct contact between university medical faculties and the Institute. Contact between the universities and the Institute such as we visualise would have a beneficial effect both upon the academic life of the Institute and the medical faculties of provincial universities.

**Note by Mr. N. M. Joshi.**

As regards the control of the Central Institute, I have no objection to the creation of the independent Governing Body for administrative purpose and also to the technical and scientific aspect being left to the Director and Professors acting as a medical faculty provided that in the matters of the number of teachers to be trained and the standards of their training as regards which the final decision rests with Government who are responsible for satisfying the needs of the country in this respect. The need for this proviso is greater if the Institute is to be created by special legislation.



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## CHAPTER XXI

### HEALTH ORGANISATION FOR DELHI PROVINCE

#### Introduction

1. In the chapter dealing with our short-term proposals for the country as a whole we made the suggestion that the Central Government should attempt to demonstrate, in Delhi Province, the effects of implementing not only our proposals but also those put forward by the other committees, which have made recommendations for post-war developments in the different fields of community life. Without a simultaneous advance in the spheres of education, agriculture, co-operation, animal husbandry, industrial development and others affecting the life and well-being of the people, we feel that the increased facilities proposed for the treatment and prevention of disease will not produce their maximum effect in improving the public health. That is why we are anxious to ensure that a social experiment of this comprehensive nature should be started, if possible, in Delhi Province. The purpose in view is to demonstrate to the country as a whole what can be achieved, through co-ordinated effort, to improve the health and general prosperity of the community.

2. We recognise, however, that, owing to the special conditions operating in the case of Delhi, it may not be possible to secure the same results in other areas not so favourably circumstanced.

3. An essential feature of the experiment should be the active association of the people, as far as possible, with the proposed ameliorative measures in every field. Such association alone can ensure that the measures adopted will yield the maximum results and that the progress achieved will be maintained and extended with the lapse of years. The ultimate purpose of all effort towards social amelioration is to make the life of the individual fuller and happier and the achievement of this purpose must have, as a pre-requisite, his conscious acceptance of the objectives that are set forth and his active co-operation in the realisation of those objectives. Our proposals for the establishment of village health committees and the association of the people with the formulation of health policy at the two levels of health administration in the province, namely, the district and the provincial headquarters, have been made with this object in view.

#### OUR PROPOSALS

4. While we recommend that the development of health services in Delhi Province should generally follow the lines indicated by us for the establishment of such services in the country as a whole, certain modifications will be necessary in order to provide for some special features which should be introduced in the Delhi scheme for certain special reasons which will be referred to later.

#### Our Recommendations for Provinces other than Delhi

5. Our main recommendations in connection with the short-term programme for the country are:—

(a) The new services introduced under our scheme should supplement and not supplant those which are already in existence in the areas concerned.

(b) While in each district in a province the scheme will be introduced in limited areas and extended over the whole territory in successive stages, the health services in the areas covered by the scheme should function all the time as one administrative unit, in order to ensure that the control exercised by the supervisory staff is effective and would extend even to the smallest local area under the scheme, namely, the village. This can be secured only by having one health authority to function in the area as a whole, because the presence of a number of independent authorities would naturally render efficient administration impossible. We have therefore recommended that the existing local authorities, which are responsible for health administration in their respective areas, should be replaced by a District Health Board, to which their health functions would be transferred. In our anxiety, however, to interfere as little as possible with the existing form of local health administration, provided the basic requirement of efficiency is secured, we have recommended that Provincial Governments may, after taking into consideration all the relevant factors, authorise large municipalities with populations of 200,000 and over to recruit and maintain their own health services, provided the general plan and level of efficiency recommended by us for such services are duly kept up. We have also stressed the need for ensuring that the two types of services are so integrated as to enable them to function in the closest possible co-operation.

(c) We have recommended the provincialisation of all branches of the health services in the areas covered by the scheme, with the exception of the large municipalities referred to above, and have defined the relationship between this provincial district health organisation and the District Health Board on the one hand, and between it and the Provincial Health Department on the other.

(d) In order to enable the district health administration to keep in touch with the views of organised medical and certain allied professions in the district on matters relating to the health services, we have recommended the creation of a District Health Council consisting of representatives of these professions, its functions being purely of an advisory character.

(e) As regards the structure of the proposed health organisation in the districts, our recommendations are that, owing to the inadequacy of trained personnel and funds, the scheme should start modestly with primary units covering populations of approximately 40,000 and that, in due course, the number served by each primary unit should be reduced to a figure ranging between 10,000 and 20,000, taking into consideration the density of population of the area concerned.

For the area covered by a sufficient number of primary units to provide a population of 500,000 to 600,000, there should be a secondary unit, which will supervise the work carried out in the primary units and will, at the same time, provide through its specialist staff and hospital and laboratory facilities a higher type of health service than that which is given through the primary units.

At the district headquarters an even higher type of health organisation will be provided when the scheme becomes developed to the stage of covering the major portion of each district. Its functions will include the direction and supervision of health administration in the district as well as the provision of all modern facilities for remedial and preventive health care.

(f) We have suggested that at the provincial headquarters a Provincial Health Board, on which district health administrations will find representation should be created in order to enable the Minister of Health to consult public opinion in defining health policy and in allotting funds for its implementation. The establishment of a Provincial Health Council, with its constitution and functions similar to those of the District Health Council, has also been recommended.

### **The Delhi Health Organisation**

6. There are certain special considerations in the case of Delhi which will necessitate, in our view, a departure from the general plan outlined for the country as a whole. These are (1) that the area and concentration of population tend to make it a case *sui generis* and (2) that Delhi should be a demonstration centre and that it is, therefore, desirable that the organisation set up here should, from the beginning, function at as high a level of efficiency as possible. We have, therefore, come to the conclusion that the Delhi health organisation should differ, to some extent, from the three million plan recommended for adoption elsewhere. At the same time the general principles underlying that plan should, as far as possible, be adhered to.

7. In the first place we recommend a modification of the primary unit suggested by us for the country as a whole during the short-term programme on the lines indicated below:—



Table showing the population, strength of staff and other provision in primary units in Delhi Provinces and in other provinces  
(Short-term Programme)

Delhi Province						Other Provinces					
Popula- tion served	No. of medical officers		No. of non- medical staff	Provision for institutional service	Provision for Domiciliary health service	Popula- tion served	No. of medical officers		No. of non- medical staff	Provision for institutional service	Provision for domiciliary health service
	Men	Women					Men	Women			
1	2	3	4	5	6	7	8	9	10	11	12
..	..	..	..	(a) A dispensary with five emergency beds.	Two medical officers,* two public health nurses, four midwives and four trained dote.	..	..	..	..	(a) A dispensary with a couple of emergency beds, and two maternity beds.	Two medical officers,* four public health nurses, four midwives and four trained dote.
20,000	1	1	34	(b) A 30-bed hospital for a group of three primary units.	..	40,000	1	1 if avail-able, particularly in the early stages of the programme.	36	(b) A 30-bed hospital for four primary units.	..

\* The medical officers shown in column 6 are identical with those given in columns 2 and 3, and those in column 12 with those in columns 8 and 9.

8. The following are the details of the staff proposed in each case:—

	Delhi Province Primary unit (20,000 population)	Other Province Primary unit (40,000 population)
1. Medical officers (male and female) . . . . .	2	2
2. Public health nurses . . . . .	2	4
3. Nurse . . . . .	1	1
4. Compounders . . . . .	2	1
5. (a) Midwives . . . . .	4	4
(b) Trained <i>daies</i> . . . . .	4	4
6. Public health inspectors . . . . .	2	2
7. Health assistants . . . . .	2	2
8. Fitter mistry . . . . .	1	1
9. Typist-clerk . . . . .	1	2
10. <i>Inferior servants</i> —		
(a) Supervisor . . . . .	1	1
(b) Other servants . . . . .	14	14

9. The population of a primary unit in Delhi Province will be half of that of a similar administrative unit in other parts of the country. The number of medical women available in India is very limited and, although it seems almost certain that the provinces will not be able to appoint women doctors in the vast majority of their primary units during the early stages of the development programme, it should be possible for Delhi Province to secure such doctors for the relatively smaller number of units that will be developed here. Our recommendations regarding the duties of the two medical officers and other members of the staff of a primary unit in Delhi are the same as those which we made in respect of a primary unit in other provinces. The smaller population, the presence of a woman doctor and the relatively larger staff for midwifery should help to make the Delhi health organisation, in the early stages, more effective than those in other provinces in promoting health work among women and children. The proposed provision for medical relief for the population as a whole is, it will be seen, higher in Delhi Province than that suggested by us for other parts of the country. The dispensary will have five emergency beds here as against two in other provinces while the 80-bed hospital will serve a population of 60,000 as against 160,000 in the other case.

10. The population of Delhi Province at the 1941 census was approximately 918,000, of which a very large proportion was living in the two cities of Delhi and New Delhi. The rural population was only about 300,000 while the two cities accounted for 615,582. Since 1941 a large increase has taken place in this urban population as the result of developments arising out of the War. Assuming that a certain proportion of this increase will remain even after the War, the estimate is made that the inhabitants of Delhi and New Delhi will together be at least 800,000 during the first five years of our health development programme, if it starts functioning some time in 1946.

11. The rural population of 300,000 should be divided into 15 primary units, which will constitute a single secondary unit, at the headquarters of which there will be a secondary health centre.

12. For the purposes of our scheme we suggest that Delhi and New Delhi cities and the Civil Lines may be taken as a single urban unit. In this area, in view of the high density of population, particularly in Delhi City, the average number of people included in a primary unit may suitably be 40,000, although certain parts of New Delhi and of Civil Lines, with their wider dispersal of inhabitants, may require a reduction of the number to 25,000 or 30,000. A secondary health unit will be required in the urban area for the supervision of the activities of these urban primary units. Co-ordination of the functions of the rural and urban secondary health units will be the responsibility of the Director of Health Services.

### THE ADMINISTRATIVE MACHINERY

13. *A single health authority for Delhi Province.*—The area of Delhi Province is 574 square miles. The average area of the districts in the eleven Governors' Provinces ranges from about 2,200 to slightly over 6,000 square miles. Delhi's population of about 918,000 at the 1941 census is much less than the average population of individual districts in a number of provinces. In Chapter XVII of this volume of the report, where we have dealt with the question of District Health Boards, we have drawn attention to the desirability of treating, as far as possible, each district as one unit for health administration and have pointed out that, in our view, the tendency should be for local administration in different fields, such as health, education and communications, to operate over a sufficiently wide area to provide adequate service to the people. We strongly recommend that a single authority should be established for health administration in Delhi Province as a whole. It may be designated the Delhi Provincial Health Board.

14. A special feature of this province is, however, that about two-thirds of its population lives in the two cities of Delhi and New Delhi, the respective populations of which were, at the 1941 census, about 520,000 and 94,000. The population of Delhi City is far in excess of 200,000 while it may well be that the population of New Delhi is now also not far from this figure. Although we have recommended that municipalities of this size may be permitted to develop their own health organisations on the lines indicated in this report, provided the desired level of efficiency is maintained, we feel that, in Delhi Province, the purpose of creating a demonstration centre will be better served by merging these local bodies into a province-wide health authority than by permitting them to maintain their separate health services, with whatever safeguards Government may impose for promoting their efficiency. In coming to this conclusion we have been influenced by the fact that the existence of one rural and two urban health authorities functioning independently in a province like Delhi, with its small area and highly concentrated urban population, must militate against the development of an efficient and integrated health service and must render difficult the formulation and execution of a unified health policy for the area as a whole.

15. *The structure and functions of the Provincial Health Board.*—In the creation of the Delhi Province Health Board, two suggestions that we put forward in connection with the establishment of District Health Boards may be followed. These are that all the local authorities in the area should find representation on the Board and that, in addition, there should be provision for a number of representatives

elected directly by the people. The Chief Commissioner of the Province should, in the initial stage, be its Chairman, though later, the Chairman should be elected. The Director of Health Services should be a member. In the absence of local knowledge we must leave the working out of details regarding the composition of the Board to the authorities concerned.

16. In our proposals for District Health Boards in the provinces we recognised the need for the concurrent acceptance of two principles. Local opinion should have the right, through the Board, of giving adequate expression to local needs and local grievances as well as of distributing the money available for health administration, which will be derived partly from local taxation and partly from Government grants. The Board must therefore have a large measure of autonomy within its own area. Nevertheless, the exercise of this autonomy should not result in a material departure from the general health policy laid down by the Provincial Ministry of Health or in any serious neglect of the Board's functions to the detriment of local health administration. Provision for these contingencies has been suggested by two recommendations that we have made, namely, (1) that the Provincial Minister should have the power to ensure compliance, by the Board, with the general health policy laid down by him and (2) that certain legal provisions that exist in the Province of Madras for enabling the chief administrative officer of the Public Health Department to recommend specific action by local health authorities in particular directions for the improvement of the public health and to enforce the carrying out of such recommendations, subject to the concurrence of the Provincial Government, should be made applicable to all the areas under our scheme.

17. The acceptance of this dual principle of encouraging the growth of local responsibility in health administration and of ensuring, at the same time, the maintenance of a reasonable level of efficiency appears to us to be essential to the success of the comprehensive programme of health development we have advocated. We therefore desire to see these recommendations of ours applied in Delhi Province also. Local public opinion will be able to influence health policy through the Provincial Health Board while the administrative control that the Central Government has over Delhi Province as a centrally administered area will enable the Central Health Minister to ensure that Delhi health administration does not depart from the policy laid down by him and to enforce desirable standards of efficiency. We understand that, under the provisions of the Delhi Laws Act, the conferment on Delhi Administration of the powers existing under any enactment in force in any part of British India is permissible. The application in Delhi Province of the provisions in Madras, to which we have referred, should therefore present no difficulty.

18. *Provincialisation of the health services.*—We have recommended the provincialisation of the entire district health organisation under our scheme in the provinces, with the exception of the health services maintained by certain large municipalities with a population of 200,000 or over. We considered this essential in the interests of uniformity throughout the province in respect of the methods of recruitment and conditions of service of the different categories of health personnel, which it would be impossible to attain if individual District Health Boards were permitted to recruit and maintain their own services. We also considered the question as to

whether it was necessary to provincialise the entire staff under each District Health Board or only the more important posts and came to the conclusion that the whole staff should be provincialised because we felt that two sections of the same health organisation, with ultimate responsibility for disciplinary control under separate authorities, would not function efficiently and harmoniously. In applying these ideas to the Delhi health organisation we must remember that there will be only one health authority in the province as a whole. Our requirements regarding uniformity of conditions of recruitment and of service will, therefore, be met by making the entire staff servants of the Provincial Health Board. Even so, it seems necessary that, in view of ensuring that the Delhi experiment becomes a success, a certain number of the higher posts such as those of the Director of Health Services and his chief assistants at the provincial headquarters should be filled, at least during the short-term programme, by persons of approved ability in the technical and administrative spheres, who will be seconded from the Central Health Services or from one of the Provincial Health Services. In view of the developments that will take place during this period, it will be for decision at the end of that period whether the same system should continue or whether the Provincial Health Board should be entrusted with the task of recruiting suitable candidates for these higher posts. It must be remembered that, by that time, a certain number of men from the lower grades of the service may have qualified, by virtue of their administrative experience and special training, for some of these important posts and that, in the circumstances, the need for importing men from the Central or Provincial health services may have disappeared.

19. *The organisation at the provincial headquarters.*—The administrative organisation at the provincial headquarters will be based generally on our recommendations for other provinces although, in view of the small size of Delhi, we are of the opinion that the full strength of Deputy and Assistant Directors of Health recommended for the larger provinces will not be required here. The fact that the Director-General of Health Services and the technical members of his staff have their headquarters in Delhi and may therefore be expected to take a prominent part in the development of the health programme is another reason against employing in Delhi the full strength of the directional staff recommended for the provinces.

20. We have purposely refrained from going into the details of the health services the Province will require. Obviously such details can be worked out only through a special investigation which takes into account existing facilities in different parts of the province and relates them to what the requirements should be in the light of the broad principles which should govern the development of the proposed organisation.

21. The creation of a Provincial Health Council for Delhi, with its structure and functions similar to those of corresponding councils elsewhere, will also be necessary in order to enable the health administration to keep itself informed of the views of medical and allied professions in all technical matters relating to the development and maintenance of the health services.

22. We have specially stressed that the new services which will be established in the provinces under our scheme should supplement and



28. *The financing of the health organisation.*—As regards the financing of the Delhi health organisation our recommendation is that the contributions from the existing local bodies, which will be merged in the Provincial Health Board, should be the same as those which we put forward in connection with the district health scheme for other provinces, namely, 30 per cent. of their income from all sources other than Government grants in respect of municipalities and 12½ per cent. in the case of rural health authorities. The additional money that will be required for the scheme should be found by the Central Government.

24. *Review at the end of seven years.*—The scheme proposed by us, if given effect to, should be subjected to review after seven years to enable stock to be taken of what has been achieved and modifications made, where necessary.

25. *Development of communications.*—In Delhi Province although communications may have been developed to a larger extent than in many other parts of the country, we desire to stress the importance of still further improvement in this direction in order to ensure that the health services we are recommending may confer the maximum possible benefit on the people.



## CHAPTER XXII

### DRUGS AND MEDICAL REQUISITES

1. We shall deal with this subject under two heads: (a) supplies and (b) control.

#### **Supplies**

2. In the forefront of our programme for the improvement of medical relief and for the prevention of disease, we have placed the provision of adequately trained doctors and the ancillary personnel without whose help a doctor's effectiveness must be substantially circumscribed. Second in importance only to the provision of such staff must come the supply of the therapeutic substances and medical appliances without which doctors and public health workers generally may be reduced to a state of virtual impotency in the practical exercise of their profession. We have had evidence to show how grave has been the lack in this country of these essentials for the public health worker and the dispenser of medical aid. At some dispensaries even drugs and appliances, which should be in almost daily use, are often not to be had at all or only in such limited quantities as to paralyse the administration of effective medical aid. In many cases, even when they are available, the cost is so high as to prohibit or at least gravely to restrict the use of what may be an essential medical requisite. An instance has been given us of a drug manufactured in this country being offered at an unconscionable price because a single firm had managed to secure the monopoly of its supply. The operations of the International Kina Bureau offer, in our view, a flagrant object lesson in the cynical triumph of commercial principles over the needs of suffering humanity. We are told, for instance, that in the year 1935-36, the actual cost of producing quinine in Bengal from home grown bark was about Rs. 6½ a pound. The Government selling price of this article was then Rs. 18 and the market rate Rs. 22 a pound. This market rate was largely decided by the Kina Bureau which controlled about 95 per cent of the world's supply of quinine. So far as the general public of this country is concerned, it is to a material extent being denied the use of some of the more effective and most needed drugs either because of the price at which they are made available or because of the limited quantities in which they are procurable. Even the cheaper and commoner drugs which are needed in daily dispensary practice are frequently not to be had as and when needed. We feel that this state of things calls for immediate attention and remedy.

3. Until the advent of the war, there was no organised attempt to see that the requirements of the country in this regard were adequately met. The Government Medical Stores served a useful though limited purpose and the initiative of a few private firms helped to lay the foundation of an indigenous drugs manufacturing industry though it was on an extremely modest scale. For the most part, however, the foreign manufacturer had a wide market in the country for his products and the middleman a lucrative field for his operations. Not being normally philanthropists, their prices were regulated by business considerations and by the desire to obtain the highest possible margin of profit. Those who could not pay, and they comprised the large bulk of the population, had just to do without.

4. Nor can the indigenous profiteer be absolved from the charge of criminal exploitation. The seas around our shores have opened up the prospect of our being able to obtain all our requirements of shark liver oil with its very high vitamin content. We are, however, informed that a good deal of what is offered on the Indian market as shark liver oil today, under conditions where control is lacking, is adulterated in some cases so grossly as to result in a denial of the full benefits to this country of great natural advantages.

5. War conditions brought about a dramatic change in certain respects in the medical drugs and requisites position of the country. The needs of the Army forced the abandonment of the old attitude of helpless dependence on outside sources of supply, which were in a position to dictate their own terms and which were liable to stoppage at any moment. Possibilities of local manufacture had perforce to be more fully explored and this was done with remarkable success in many cases. Careful investigation provided efficient substitutes for some imported drugs and medical requisites, very often at a much lower cost, while the possibilities of local manufacture were in many cases established beyond a doubt. The prejudice against Indian made drugs came to be slowly reduced through the compelling force of events. Certain requisites had either to be manufactured in the country or be done without. This stimulus proved effective and in the case of a few medical requisites a deficit was even turned into a surplus position.

6. We should here also like to emphasize the success which has attended the policy of associating non-medical scientific men with the organisation and development of the drugs industry in this country and to express the hope that this policy will be continued in the future.

7. Some idea of the change that has been brought about by the stress of circumstances during the past 8 or 4 years can be obtained from the following illustrations:—

Name of Drug	Annual peace time consumption in India (estimated)	Estimated Indian production 1945
(1) Amyl nitrite . . . .	140,000 caps.	2,000,000 caps
(2) Argenti Nitras . . . .	5,000 lbs.	10,000 lbs.

We do not by any means wish to suggest that the position is now entirely satisfactory. We do, however, wish to point out that the story of what has been accomplished in this war, though it is no more than a beginning, is a convincing proof that, given the will, organised effort can, with the help of the scientific assistance which it is possible to command, make this country almost, if not entirely, self-sufficient in the matter of drugs and medical requisites. It would be little short of a national calamity if even the position now attained after 5 years of war were allowed to be lost when the urge to maintain and improve it has ceased to operate or if other considerations were permitted to intervene and stifle a young industry of the greatest national importance to the country. The administration should be chargeable with gross negligence if the position now attained were not made the starting point for building up an indigenous source of supply, which will be able to meet the overwhelming bulk of the country's demand for medical requisites.

8. We have asked ourselves the question what are the objections and difficulties in the way of the country being made self-sufficient in this sphere. We detail below the considerations of major importance which appear to us to call for examination in this connection.

(1) It may be urged that among our requirements are some which it would not be an economic proposition from the point of view of cost to produce in the country.

(2) It may be contended that either the raw material or the basic requisites for manufacture in India are at present lacking in certain cases.

(3) Certain drugs and appliances are of so highly specialised a character that it may take a very long time to produce these in India of a comparable quality.

(4) Certain medical requisites are covered by patents and it may therefore not be possible to overcome the monopoly position occupied by them.

9. So far as (1) is concerned, we can only say that a careful balance will have to be struck between the claims of a nation's health and economic considerations. India should be gravely unmindful of the teaching of history if she risked once more the interruption or limitation of essential medical supplies to the country through human greed or world causes over which she had no control, because she was unwilling to pay a reasonable premium to insure against such a calamity. Whether in a particular case the insurance is reasonable or not would of course need to be carefully calculated. We ourselves believe that the cases in which it would be found to be more advisable to obtain supplies from abroad on this ground would be rare exceptions to the general rule that the medical requirements of the country should be produced in the country.

10. In considering cases falling under (2), it has impressed itself upon us that there has been a tendency too easily to accept any suggestion that this country cannot meet a particular requirement from its own resources. The case of pyrethrum affords a striking illustration of this. The legend had grown up and it had been generally accepted that pyrethrum could only be grown as a commercial proposition in Kenya and Japan. This may have been founded on an honest belief or it may have been sedulously fostered in order to support a gilt-edged monopoly. When war time needs force a more rational method of dealing with such monopolies, however, it did not take long to liquidate this misconception. Not only has experience shown that it is possible to grow pyrethrum of high quality in Kashmir, Assam and the Nilgiris but more extensive experiments have suggested that pyrethrum, with a sufficiently high pyrethrin content to make its production a commercial proposition, might be grown under such diversely varying conditions as those prevailing in Mysore, the Central Provinces, the Orissa States and Chittagong. We feel that, given a genuine desire to explore and exploit to the utmost the resources of the country, the list of medical requisites which cannot be produced in India will shrink to extremely limited proportions. Where the basic requisites of production are not being or cannot at present be manufactured in the country, there should be a serious examination of the possibilities of such manufacture.

11. We have been told that such synthetic products for instance as mepacrine, D.D.T. and the sulphanamide group require basic essentials which are the product of a heavy chemical industry at present non-existent in this country. If this is so, then an additional argument is provided for giving adequate aid and encouragement to bring an Indian heavy chemical industry into being. Such an industry we consider fundamental to meet the needs of the country.

12. If it seems impossible to produce these chemicals at a reasonably early date in India, then we suggest that agreements with producing countries should be made whereby India would be able to get her immediate requirements in exchange for her specialities.

13. Turning to the cases which fall under (3), we recognise that it may require a heavy expenditure of time, money and effort to equal or even approach the level of workmanship and quality which some countries have attained in the production of certain highly specialised medical equipment. A Leitz microscope for instance is in a class by itself and it may be long before its quality can be equalled by its competitors. Nevertheless we believe that, through a determined effort, the range of products which are at present supplied from outside the country can be very materially reduced and that, even if in some cases it may not be possible for a considerable time to equal the quality of an imported article, it may be possible to produce a fair working substitute for general use. It is only in this way that a body of scientific experience and of skilled craftsmen can be built up to help the country to become eventually self-sufficient in respect of its essential requirements in this particular field. So far as drugs are concerned, we are confident that provided adequate provision is made for research, and if appropriate aid and encouragement are given to private enterprise, no fear need be apprehended that the quality of the Indian produced article will not come up to the standard which may be laid down for its quality under statutory enactments, as indeed has been found during the last emergency when, given the equipment, India was able to produce drugs of a very high and exacting standard.

14. We would suggest that universities should be encouraged to undertake research with a view to the production, in this country, of drugs which India has now to import and the discovery of new or improved drugs.

15. We realise that the patents referred to in (4) constitute a difficulty. Our general view is that normally such patents tend to operate so far as the price factor in relation to the general public is concerned in the manner of all monopolies and are therefore *prima facie* to be deprecated if the people's health is our first consideration. In the case therefore of medical requisites covered by patent, whose availability at reasonable prices is considered essential for the health needs of the people, every endeavour should be made to produce in the country cheaper substitutes which can be manufactured for general use. To give an example, certain products incorporating Kurchi have been found to be an efficient substitute for Emetine products in the treatment of amoebic dysentery and the plant is to be found in all parts of the country. Should, however, such endeavours prove infructuous, an attempt should be made by Government to secure the patent rights of the article for the country

to ensure its sale and possibly its manufacture in the country at reasonable prices.

16. We have a recommendation to make in this connection. The first is that a small committee, mainly but not entirely technical in composition, should be appointed to examine the question of the requirements of the country in respect of drugs and other medical requisites. The following are some of the more important matters which they should investigate:—

(a) What are the drugs and other medical requisites essential for general use in the country?

(b) What practical steps should be taken to ensure their manufacture in the country in sufficient quantities and their sale at a price which will make them available to all who need them?

(c) What are the circumstances which would justify the conclusion that the manufacture of any of these in the country is inadvisable?

(d) What should be the respective fields of Government and of private enterprise in the manufacture of these requirements?

(e) What aid and assistance should be given to private agencies in such cases and under what conditions?

(f) What machinery should be established to develop research regarding drugs and other medical requisites and their production in India and to ensure the continuity and co-ordination of such research?

(g) What machinery should be set up to ensure a steady flow of trained technical personnel?

While we have suggested the examination of these questions by a special *ad hoc* body, there are certain general conclusions which we feel we should record.

17. The final responsibility should, in our view, rest with the Government for seeing that the essential needs of the country in respect of all important medical requisites are met and this responsibility should be interpreted as covering the necessity for ensuring that these requirements are met satisfactorily in regard to quantity, quality and price.

18. We believe that it should be possible adequately to provide for these essential needs through a combination of private enterprise suitably assisted where necessary, and production by the State where this is found to be in the public interest.\* We feel for instance that Governments should themselves produce the biological products which are necessary for the prevention and treatment of epidemic diseases. It is not in the public interest that Governments should be at the mercy of private agencies in regard to the supply of such requirements which may be needed at very short notice, in large quantities, of a high standard of quality and at reasonable prices. We are therefore of the view that Governments should themselves undertake the production and storage of such prophylactic sera and vaccines as are required for use in the case of cholera, plague, smallpox, etc., to meet their own estimated requirements for use through their own staff

\* In the opinion of one of our colleagues (Mr. N. M. Joshi) the production and distribution of drugs and their medical requisites should be undertaken by the State and not be left to private enterprise.

and at their own institutions or at institutions under the control of local authorities and of missionary or other recognised charitable organisations imparting medical relief. Those Provincial Governments which do not want to undertake this responsibility, may find it possible to make arrangements with the Central Government for the supply of their requirements from the Central Laboratory or may combine with other Provincial Governments to establish common centres of production. These should not, however, be made a source of profit. If Governments wish to rely to a limited extent on private enterprise to supplement the supply of such prophylactic biological products from their own laboratories, there can be no objection to such a course but we consider that their main reliance should be on their own production or on the production of other governmental sources with which they have entered into an agreement for the supply of their requirements. This we believe is in accordance with the practice prevailing in Australia, and even in U.S.A. we understand that a number of States manufacture all the biological products they need. The Governments in India, Central and Provincial, should be charged with the duty of watching progress and taking such measures as may, from time to time, be necessary to further the growth and development of the drugs and medical appliances industry in the country.

### Control

19. The importance of maintaining adequate standards of purity and potency in the drugs and medicines used in connection with the prevention and treatment of disease can hardly be over-emphasized. This country has suffered much in the past from the lack of organised control and supervision over therapeutic substances and medical appliances. The unscrupulous have reaped a rich harvest at the cost of a long suffering public. There have, it is true, emerged a number of reputable indigenous firms which have done much, under extremely difficult circumstances and in the face of severe handicaps, to initiate the beginnings of a sound and reliable drugs and medical appliances industry in the country. The need for supervision and control has, however, grown more insistent with the ever-widening range of medical substances and appliances that the march of science is from time to time bringing into existence and general use.

20. Even in a country like the United States, where private as opposed to state manufacture is so generally accepted as a national industrial policy, all commercial concerns manufacturing drugs or biological products must obtain a license to do so from the State concerned if the products are for use only within the State, and from the Federal Public Health Service if these are to be permitted entry into inter-State commerce. The grant of such a license is preceded by an examination of the proposed plan of manufacture and of the qualifications of the personnel employed as well as by an inspection of the plant. Samples of the products are also taken periodically for tests in regard to purity, potency, expiration date and other criteria, in order to ensure that the standards laid down are being observed.

21. Similarly, in the United Kingdom, biological products can only be manufactured under a license which is granted after careful examination and enquiry and is liable to cancellation at any time if the quality of the product or the conditions of its manufacture are found to be unsatisfactory.





## CHAPTER XXIII

### INDIGENOUS SYSTEMS OF MEDICINE

1. In considering the question of the place which the indigenous systems of medical treatment should occupy in any planned organisation of medical relief and public health in the country, we are faced with certain difficulties. We realise the hold that these systems exercise not merely over the illiterate masses but over considerable sections of the intelligentsia. We have also to recognise that treatment by practitioners of these systems is said to be cheap, and it is claimed that the empirical knowledge, that has been accumulated over centuries, has resulted in a fund of experience of the properties and medicinal use of minerals, herbs and plants which is of some value. Further, the undoubted part that these systems have played in the long distant past in influencing the development of medicine and surgery in other countries of the world has naturally engendered a feeling of patriotic pride in the place they will always occupy in any world history of the rise and development of medicine. This feeling has not been without its effect on the value which is attached by some to the practice of these systems.

2. We are unfortunately not in a position to assess the real value of these systems of medical treatment as practised today as we have been unable, with the time and opportunities at our disposal, to conduct such an investigation into this problem as would justify clear-cut recommendations. We do not, therefore, propose to venture into any discussion in regard to the place of these systems in organised State medical relief in this country. We do, however, say quite definitely that there are certain aspects of health protection which, in our opinion, can be secured wholly or at any rate largely, only through the scientific system of medicine. Thus public health or preventive medicine, which must play an essential part in the future of medical organisation, is not within the purview of the indigenous systems of medical treatment as they obtain at present. This in no way reflects upon these systems. It has, however, to be recognised that great improvements have taken place in the field of public health as the result of the many discoveries of science which are and can be implemented only through the scientific system of medicine and through personnel trained in such a system. It is also to be recognised frankly that the indigenous systems of medical treatment do not at present deal with such vital aspects of medicine as obstetrics, gynaecology, advanced surgery and some of the specialities. Above all it is necessary that we should keep prominently before our eyes the intimate relation between science and the advancement of medicine. No system of medical treatment, which is static in conception and practice and does not keep pace with the discoveries and researches of scientific workers the world over, can hope to give the best available ministrations to those who seek its aid.

3. A recent article in the Indian Medical Gazette draws attention to this connection so vividly that we feel a quotation from it will be instructive:—

“The science of medicine” it says “is a very ancient one. It progressed slowly throughout the earlier ages of

history—such slow advance, as there was, being arrested from time to time by religious prejudice or by undue reverence for alleged authority..... It was not until the middle of the 19th century that medical science became firmly established on a secure foundation. The invention of the compound microscope, the rapid development of Organic Chemistry and latterly of Bio-Chemistry and Bio-Physics have led to such an advance that we can say with truth that 95 per cent. of the total corpus of knowledge with regard to the working of the human body has been obtained within the life time of men who are still with us."

"It may surprise some to know that nearly all advances in the science of medicine now come from men who have nothing to do with medical practice or with the care of the sick but who have a special knowledge of and training in the fundamental sciences of Physics, Chemistry and Physiology .....

Science is one and indivisible. No advance is possible with one sub-division of knowledge without its reflection in all other sub-divisions, and rejoicing over a discovery is not to be confined to the members of the particular scientific band immediately concerned."

The article goes on to point out that it is the lack of appreciation of these elementary facts that is at the root of our trouble in getting scientific medicine placed in its proper perspective.

4. We feel that we need no justification in confining our proposals to the country-wide extension of a system of medicine which, in our view, must be regarded neither as Eastern nor Western but as a corpus of scientific knowledge and practice belonging to the whole world and to which every country has made its contribution. We feel that it would be unfair and unjust merely because some other method of treatment is said to be cheaper, to deny to any one in this country the benefit of the scientific system and of the daily growing volume of research and achievement in the wide world of science.

5. We have been informed that in China and Japan, a moratorium extending to a definite period of years was declared after which the practice of the indigenous systems in those countries would not be recognised. We were further told by Dr. Ognev, the Soviet Representative, that indigenous systems of medical treatment were nowhere recognised in the Soviet Union. This, however, is a subject on which we are unable to make any recommendations so far as this country is concerned. We feel that it should be left to the Provincial Governments to decide what part, if any, should be played by the indigenous systems in the organisation of Public Health and Medical Relief. It is for them to consider, after such investigation as may be found necessary, under what conditions the practice of these systems should be permitted and whether it is necessary, either during some interim period or as a permanent measure, to utilise them in their schemes of medical relief.

What we have said in regard to the indigenous systems applies generally to Homeopathy also.\*

We have recommended the establishment of a Chair of History of Medicine in the proposed All-India Medical Institute and have suggested that one of its functions should be the study of these systems in view of the importance of investigating the extent to which they can contribute to the sum total of medical knowledge.

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\* Three of our colleagues (Drs. Butt, Narayan Rao and Vishwa Nath) desire to make a definite recommendation suggesting the free utilisation of the services of persons trained in the indigenous systems for promoting public health and medical relief in India. Their note will be found at the end of the next chapter.



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## CHAPTER XXIV

### REGULATION OF THE PROFESSIONS RESPONSIBLE FOR HEALTH SERVICES TO THE COMMUNITY

#### A. Regulation of the Medical Profession

1. In India the treatment of sick persons is practised by two classes of individuals, those who possess registrable qualifications in modern scientific medicine and those who do not. It is part of the democratic conception that the individual citizen has the absolute right to take his ailments for treatment to anybody he chooses, but it is also part of the individual citizen's right that he should have an exact comprehension of the pretensions to competence of the individual he employs. Practitioners of the scientific system of medicine are, the world over, subject to more or less rigid regulation, the degree of such regulation and the authority from which it is derived varying with different countries.

2. In the United Kingdom this function is vested in the General Medical Council of Medical Education and Registration of the United Kingdom which was established by the Medical Act of 1858. By the Medical Act of 1886 this body has been vested with the duty of securing the maintenance of such standards of proficiency from candidates at the qualifying examinations for entry into the Medical Register as would guarantee "the possession of the knowledge and skill requisite for the efficient practice of medicine, surgery and midwifery." For this purpose the General Medical Council was empowered to appoint Inspectors of Examinations to attend all or any of the qualifying examinations and "to report to the General Council their opinion as to the sufficiency or insufficiency of every examination which they attend and any other matters in relation to such examination which the General Council may require them to report".

3. In India the Indian Medical Council was established by the Medical Council Act of 1933, but its functions differ materially from those of the General Medical Council in the United Kingdom. It has not been authorised by law to maintain an All-India Medical Register. Moreover, the basic qualifications for medical registration are those of medical licentiates, a body of practitioners who are the concern of the Provincial Medical Councils. The maintenance of Medical Registers and the supervision of the basic qualifications required for entry into them are, at present, responsibilities entrusted to Provincial Medical Councils and Faculties. The supervision of the Indian Medical Council is, as yet, restricted to certain medical qualifications which are granted by Indian Universities and which are incorporated in the First Schedule of the Indian Medical Council Act.

4. We consider this position unsatisfactory. We are recommending that, for the future, there should only be one basic medical qualification for entry into the profession throughout India and that the portal of entry should be a University degree. The production of the licentiate type of doctor will cease after some time if these recommendations of ours are implemented by the Governments in India and the difficulty which was responsible for the dropping of

the proposal for an All-India Medical Register in 1933, namely, the co-existence of the graduate and licentiate types of medical men, will also disappear in due course. In these circumstances we recommend that the Medical Council of India should be empowered to maintain an All-India Register when the training of licentiates ceases throughout the country. One of us (Dr. Vishwanath) considers that, in such a register, all the existing graduates and licentiates should be eligible for inclusion. With the creation of the All-India Medical Register the functions of the Medical Council of India would approximate closely to those of the General Council of Medical Education and Registration of the United Kingdom in the definition and maintenance of minimum standards of efficiency for medical education, while the disciplinary functions of the latter body should, we suggest, remain as at present with the provincial councils.\*

5. We, however, consider it desirable that provision should be made for the right of appeal in disciplinary cases to the Medical Council of India. In the United Kingdom, in certain circumstances, the right of appeal from disciplinary decisions by the General Medical Council lies to the Privy Council. We recommend that, in similar cases in India, a further right of appeal should lie to the Federal Court of Judicature.

6. In the foregoing paragraphs we have considered the regulation of qualified or registered practitioners. We shall now consider the case of those falling within the remaining categories, *viz.*, those not in possession of qualifications in modern scientific medicine.

7. The need for restricting the right to prescribe drugs in the British Pharmacopoeia and to practise scientific medicine by unqualified and unregistered personnel was emphasised in our discussions, and one of our members (Dr. R. A. Amesur) desired that we should recommend that Government should enact legislation providing that—

- (i) no medical practitioner shall be entitled to affix the designation "Doctor" before his name unless he is a registered medical practitioner in modern scientific medicine;
- (ii) no person shall be entitled to prescribe drugs which are in the British Pharmacopoeia, especially injections and poisonous preparations, unless he is a registered medical practitioner and
- (iii) those who practise the Unani or Ayurvedic system of medicine may style themselves as "Hakims" or "Vaidyas" as the case may be.

8. We are agreed that the public is entitled to know the exact credentials of the persons on whom they call for advice and treatment of disease and to protection against fraudulent imposition, and that it should be impossible for any such person to use a style or appellation suggesting the possession of qualifications other than those actually held by him. It must, however, be remembered that by long established practice the use of the title "Doctor", which in

\* Two of our colleagues (Dr. Vishwa Nath and Dr. A. H. Butt) are not in agreement with the recommendations set out above. They state "In our opinion the functions as at present exercised by the Provincial Medical Councils and the All-India Medical Council are properly discharged and there is no need for any change"

strict accuracy should be restricted to the holder of a degree of Doctor of Medicine, has come to imply in the minds of the public any qualified practitioner of modern scientific medicine. Further, the title "Doctor" is assumed with complete propriety by any person who holds the Doctor's Degree of a Faculty of a University, and although the term has come usually to imply in the mind of the public that the holder is a medical practitioner, the title is legitimately used by many among whom are included eminent scientists, legal practitioners and divines. While, therefore, we feel that there is much justification for the principle underlying our colleague's first recommendation, we are unable to make the recommendation to Government in the exact terms proposed by him.

9. We consider, however, that legislation restricting the activities of persons not qualified in modern scientific medicine is desirable and overdue, and we recommend to the Government the propriety of the enactment of such legislation which, we suggest, should provide that no person shall be entitled to use the style or appellation of "Doctor" other than those who (a) hold the Doctor's degree of a Faculty of a University recognised by the State, or (b) are practitioners qualified to practise modern scientific medicine.

10. With regard to our colleague's second recommendation, we agree that the laxity with which unqualified persons prescribe or recommend drugs constitutes a nuisance which often amounts to imposition upon the public, but the imposition is one for which the public largely have themselves to thank. So long as the drug recommended or prescribed is innocuous restrictive legislation seems hardly justified. Rule 65(9) of the Drugs Rules, 1945, under the Drugs Act, 1940, provides that a number of poisons, which are included in Schedule H of these Rules, shall not be sold in retail except on and in accordance with a prescription of a registered medical practitioner. But Schedule H does not contain all the poisons enumerated in Schedule E of the same rules. We consider that, if Schedule E can also be included within the operation of Rule 65(9), our colleague's recommendation would be met adequately and that any further restrictive legislation is of doubtful advisability and practicability. The remedy for the abuses which undoubtedly exist seems to us to lie rather in the more rigid application of existing legislation than in the enactment of new.

11. We turn now to our colleague's third recommendation. We have indicated clearly our support to the principle that the public is entitled to know the full credentials of any person who is employed in a healing capacity, and we have indicated elsewhere that we do not feel competent to make any recommendations regarding the organisation and regulation of indigenous systems of medicine. Should such recommendations be desired by Government we consider that they should be made by the leading authorities of the systems concerned. We therefore confine ourselves to the suggestion that Provincial Governments, if they decide to recognise these systems, might, with profit, follow the example of the Government of Bombay and enact legislation by which all persons practising any form of the healing art are compelled to secure registration in a schedule or schedules appropriate to the system in vogue and their qualifications in such system.

12. We would also point out that the terms "Hakims" and "Vaides" are honourable titles of considerable antiquity, and it is by no means clear to us why persons entitled to use these honourable appellations should desire to assume any other.

13. Three of our colleagues (Drs. Butt Narayanrao and Vishwa Nath) desire to make a more positive recommendation than that indicated in paragraph 11 above regarding the training of practitioners in the indigenous systems of medicine and their utilisation for promoting public health and medical relief activities in the country. They state "We are of the opinion that the teaching of indigenous systems of medicine should be regulated by the State. The Bombay Medical Practitioners Act, 1938, represents in regard to registration, the medical curriculum and examinations preliminary to registration, a step in the right direction. Practitioners trained and registered under the requirements of the above Act, or similar legislation, should be freely utilised for promoting public health and medical relief in India."

#### B. Regulation of the Dental Profession

14. The profession of dentistry is as yet almost totally unorganised in India and no legal provision exists for its regulation. The Bengal Dentists Act makes some provision for regularising dental education and introduces the registration of dentists, but it contains no provision to restrict the practice of dentistry by unregistered persons nor does it compel registration. In the absence of suitable dental legislation to provide for dental practitioners and the prohibition of practice by unregistered persons dentistry as a profession can make little real progress. We are informed that considerable thought has been given to dental legislation in the Punjab and Bombay but that its enactment has been postponed until after the war.

15. We recommend that legislative measures similar to those which we have recommended in respect of the profession of pharmacy be enacted for the dental profession and that Central and Provincial Dental Councils be created. The latter should be charged with the duty of recognising training institutions, creating and maintaining dental registers and with the disciplinary regulation of the profession, subject to appeal.

16. As in the case of pharmacists provision should be made for the inclusion in the Provincial Registers of persons who, though not properly qualified, have been engaged in the practice of dentistry for a stated number of years. Thereafter the door of entry to the profession should once and for all be closed to such persons and restricted to the holders of approved dental qualifications.

17. In the draft legislation for the constitution of the Punjab Provincial Dental Board it is suggested that, for the first five years, the Board should consist of nine members to be appointed by the Provincial Government, *viz.*,

(a) Inspector General of Civil Hospitals . . . . .	1
(b) One Dentist being a member of the Faculty of Dentistry of the Punjab University . . . . .	1
(c) Five Dentists holding one of the qualifications specified in the Schedule . . . . .	5
(d) One Medical Practitioner being a member of the Faculty of Medicine of the Punjab University . . . . .	1
(e) One medical practitioner nominated in their behalf by the Punjab Medical Council . . . . .	1

After the 5 years during which the foundations of policy and administration should be laid, it is recommended that the Board should be remodelled on a more elective basis and should elect its own Chairman. The constitution then proposed is—

- (a) Two Dentists being members of the Faculty of Dentistry of the Punjab University . . . . . 2
- (b) Two Dentists elected by the Northern India Dental Association . . . . . 2
- (c) Three persons elected by and from among the registered dental practitioners . . . . . 3
- (d) Two registered medical practitioners to be elected by the Punjab Medical Council, one of whom shall be a member of the Faculty of Medicine in the Punjab University . . . . . 2

We consider that the principle underlying these proposals is sound and that they may appropriately form a model for the creation of Provincial Dental Councils.

18. The Central Dental Council should, as in the case of the Central Council of Pharmacy, be concerned with the direction and co-ordination of the activities of the Provincial Councils, the definition and maintenance of minimum educational standards, which implies the right of inspection and recognition of any training institution, the maintenance of an All-India Dental Register, the disposal of appeals against disciplinary decisions by the Provincial Councils subject, as may be necessary, to the directions of the Federal Court and the regulation of reciprocity within and without India.

#### **(C). Regulation of the Nursing Profession, including those of Midwives and Health Visitors**

19. In considering the organisation and regulation of the nursing profession we have had the advantage of the advice of the Nursing Sub-Committee appointed by us and composed of senior members of the nursing profession whose collective experience combines intimate knowledge of nursing conditions in India, the United Kingdom and the United States, with long experience of nursing administration and education. These experts were further fortified by the recommendation of a Conference of Nurses from all parts of India.

20. At present the regulation of the nursing profession which includes midwives and health visitors, is vested with provincial Nursing Councils, of which there are 10 and which maintain registers of persons who have completed approved courses of training in institutions recognised by them for the purpose and have passed the prescribed examination. Persons so registered are entitled to practise their profession primarily in their own provinces, but arrangements for reciprocity with other provinces exist to a degree which varies with the Nursing Council concerned. In addition, certain Examination Boards award certificates of proficiency in Provinces and Administrations where Nursing Councils do not exist. But these bodies are rightly tending to obtain recognition by, and affiliation to, neighbouring Provincial Nursing Councils.

21. There are, however, many unsatisfactory features in the composition and functions of the Provincial Nursing Councils. It seems obvious to us that a Council designed to regulate the training and practice of the nursing profession should consist primarily of members of the profession it designs to regulate. Yet in the



majority of provincial medical councils trained nurses, midwives and health visitors are in a minority, and in some they are not included at all. At the Conference of Nurses, to which reference has been made, it was unanimously agreed that  $\frac{2}{3}$  of the members of each Provincial Council should be drawn from the nursing profession, including midwives and health visitors. This proposal would leave ample scope for the representation of the medical and educational professions whose advice would be of value to the interests of the nursing profession. We consider that this recommendation is reasonable and accept and endorse it.

22. We are informed that there is at present no uniformity in the classification of divisions and nomenclature in Provincial Registers maintained by the Provincial Councils. This lack of uniformity in the divisions of the registers has led to much confusion, postponement of inter-provincial reciprocity and wrong ideas as to the standard of nursing education. We are informed that this is in the process of rectification and that the majority of Provincial Councils have agreed upon the form which we consider will promote accuracy in the maintenance of the registers concerned. The agreed form is set forth in Appendix 48.

23. While the use of this agreed form will promote uniformity in the Provincial Nursing Registers, there is scope for improvement in respect of the portion which deals with "Nurses Register". This portion as at present designed restricts registration to certificated nurses. In our recommendations for the employment of demobilised nursing personnel from the Nursing Services we have pointed out that there exist considerable numbers of this personnel who have been unable to qualify for the senior certificated course owing to a limited knowledge of English and we have recommended special facilities for them in respect of the junior certificated course. We are informed that a fair proportion of this class may not in the time available, be able to complete their studies either for the required basic educational qualifications or for the vernacular professional tests. These persons, nevertheless, possess considerable experience in nursing procedures and we consider that it will be advisable, in order that their services may be utilised, as they should be, to create in the Provincial Registers, as has been done in the U.K., provision for "Assistant Nurses", i.e., personnel capable of nursing the sick under the supervision of fully trained nurses (Ref. Nurses Act, 1948, Roll of Assistant Nurses, A.C.I. 1532—given in Appendix 49). We consider this innovation not only desirable, but necessary for the fullest possible use, in the public services, of the available nursing experience in India.

24. The need for an All-India Nursing Council to co-ordinate the activities of the Provincial Councils, to lay down minimum educational standards and to safeguard their maintenance has long been emphasised by the nursing profession itself, and was recommended with emphasis by the Central Advisory Board of Health at its meeting in Calcutta in 1941. We fully agree as to the necessity of such a Council and endorse the recommendation for its immediate creation. We understand that the Government of India is actively considering this matter and that the necessary legislation is in the drafting stage. Our suggestions for the composition of the Central Nursing Council are given in Appendix 50. We consider that

the proposed All-India Nursing Council should not be restricted to the maintenance of educational standards.

25. The recognition of an individual institution for the purpose of training of nurses, midwives and health visitors should continue to vest in the Provincial Nursing Council, but provision should be made for the Central Council to have the right of inspection of recognised training institutions and, in the event of such an institution not maintaining the minimum necessary standards, of withholding recognition to persons trained in those Schools. This can best be achieved by the creation of an All-India Nursing Register with appropriate divisions. The Nursing Council Act should possess Schedules for the entry of approved qualifications in general nursing, higher nursing, public health nursing, midwifery and health visiting, and the All-India Register maintained under the Act should have divisions corresponding to the Schedules. Persons trained in institutions which do not, in the opinion of the All-India Nursing Council, come up to the minimum standards prescribed should not be eligible for inclusion in the All-India Register. If the Provincial Council which has recognised such institutions should deem it expedient, notwithstanding the withholding of Central recognition and registration, to continue approval of such persons and their inclusion on the Provincial Register, this inclusion shall have purely local validity within the province concerned.

26. The power of disciplinary action should continue, in the first instance, to be vested, as at present, in the Provincial Councils, but we are of opinion that there should be a right of appeal to the All-India Nursing Council over their decisions, with additional provision for further appeal to the Federal Court in circumstances similar to those in which in the United Kingdom appeal lies to the High Court against the decision of the General Nursing Council. Questions of reciprocity with other countries should be the concern of the Central Nursing Council and not of the Provincial Councils.

#### **D. Regulation of the Pharmaceutical Profession**

27. In considering the organisation and regulation of the pharmaceutical profession we have had the advantage of the advice of a Pharmaceutical Sub-Committee composed of eminent pharmacological and pharmaceutical authorities, which we appointed. For the regulation of pharmaceutical practice, the Sub-Committee advised the establishment of an All-India Pharmaceutical Council and Provincial Pharmaceutical Councils, regarding the composition of which they made specific recommendations which will be found in Appendix 51 in Volume III of this report. Broadly speaking, their recommendations are to the effect that Pharmacy Councils representative of the pharmaceutical trade, education and other pharmaceutical interests should be set up in each province. their functions being as under :—

- (1) to maintain a Register of all registered pharmacists of the province and to register the names of newly qualified pharmacists on payment of a prescribed fee;
- (2) to maintain the standard of education of students;
- (3) to specify the drug establishments or hospitals where apprenticeship training may be undertaken;
- (4) to conduct and maintain the standard of examinations;

- (5) to maintain such disciplinary control over the practice and profession of pharmacy as may from time to time be necessary;
- (6) to advise the Ministry of Health in respect of any regulations for the distribution of drugs, including poisons, dangerous drugs and drugs of addiction and
- (7) to advise on any other legislative control that may be necessary in this connection.

The functions of the Central Pharmaceutical Council would be to direct and co-ordinate the activities of Provincial Councils. It would include nominees from the Provincial Councils, representatives of the pharmaceutical teaching profession and of the medical profession. The Sub-Committee further recommended that, in disciplinary cases, the right of appeal from the decision of the Provincial Council should lie to the Central Pharmaceutical Council.

28. We accept the advice of this Sub-Committee and recommend that Central and Provincial Pharmaceutical Councils of the character recommended by it should be established by legal enactment. We further recommend that in disciplinary cases the decisions of the Central Pharmaceutical Council shall be subject to the direction of the Federal Court to the same extent as that of the Privy Council under the Pharmacy and Poisons Act, 1933 (given in Appendix 52) over similar cases in the United Kingdom.

29. We endorse the opinion of the Sub-Committee that it is essential to raise the professional standing of those (other than medical practitioners) engaged in the handling of drugs and that, to this end, legislation designed to protect the public from incompetence and to safeguard the interests of the qualified pharmacists should be enacted. The profession of pharmacy should be reserved for pharmacists and the latter should be restricted to their profession and should not be permitted to undertake functions such as prescription of medicine, administration of anaesthetics, etc.

30. Concerning pharmaceutical education, the Sub-Committee were of the opinion, in which we concur, that the present standard of training of those engaged in the practice of pharmacy is unsatisfactory and that a revision of the educational system is necessary. We have dealt fully with this subject in Chapter XVIII of this volume where we have discussed the question of pharmaceutical education.

31. We make the following additional recommendations:—

- (1) The Drugs Rules 1945 under the Drugs Act 1940 should be brought into force either before or concurrently with the proposed pharmaceutical legislation.
- (2) Every institution and commercial firm engaged in the handling of poisonous drugs should be compelled to employ a person who is registered as a Pharmacist or Student Pharmacist, i.e., a person who has either successfully completed the requirements of the licentiate course or the degree course or is undergoing apprenticeship to that end in such conditions as may be prescribed. This envisages a Register of Pharmacists. Such Register will of necessity on its inception include those persons who have been engaged in the profession at

Pharmacy, albeit without due qualification, for a stated number of years, but we consider that such persons before being admitting to the Register should be required to pass a practical examination. Subsequent admissions to the Register should be confined to persons who have acquired the status of graduate or licentiate pharmacist, and to *bona fide* registered students aspiring after those qualifications.

32. The Central Pharmaceutical Council should maintain a Register of all qualified pharmacists in two Schedules. Schedule A should contain the names of graduate pharmacists and Schedule B of licentiate pharmacists. Each Provincial Council should also maintain a Register which will include the names of student pharmacists and all persons who, by long standing practice of pharmacy without the necessary qualifications, become eligible for admission to the Register on successfully passing a practical examination. These two classes of persons should not be eligible for inclusion in the two Schedules of the All-India Register.

33. Such considerations, if any, as may arise concerning the reciprocity with foreign countries should be the concern of the Central Pharmaceutical Council.

34. An extract from the Pharmacy and Poisons Act, 1933, of the United Kingdom relating to the removal of pharmacists from the register is reproduced as Appendix 52.

35. One of us (Mr. N. M. Joshi) holds the view that the power of regulating entry into all the professions dealt with in this chapter should not be given to autonomous organisations which are largely composed of the members of the respective professions and that the final power for taking decisions should rest with Governments, particularly in view of the great need for producing, as fast as possible, large numbers of all types of health personnel. His note is given below. We understand that, in the Punjab, a local authority has been given power to enforce prohibition in respect of midwives when it is satisfied that there is a sufficient number of qualified midwives in its area. We suggest that such a provision will meet the case in regard to other types of health personnel also.

**Minute by Mr. N. M. Joshi on the chapter dealing with the regulation of the professions responsible for health services**

When the greatest need of the country is to multiply as fast as we can the personnel necessary for the medical service of the community including doctors, nurses, midwives and the dentists, I am not in favour of handing over the final power and responsibility of laying down standards of knowledge and experience for entry into these professions and the standards of examinations to the autonomous organisations of these different professions as is suggested by the majority of the Committee. Taking human nature into consideration there is some risk of these organisations using their power, in the interest of their particular professions for unnecessarily restricting the entry of fresh entrants into the profession. Moreover while the power and responsibility for the entry into some other professions and occupations is not handed over to their respective autonomous organisations, the anti-social effect of irresponsible and selfish use of the power

by organisations of the various medical services cannot be easily realised by them. I, therefore, suggest that under the present circumstances when the responsibility for the provision of a sufficient number of the personnel for the medical services is on the Government, the final power and responsibility for giving entry into these professions should be with the Government and the power of these autonomous organisations should only be advisory and recommendatory. It is true that these powers are to be given to these organisations by legislatures and the legislatures can also take them away if they are wrongly used. But legislation cannot be changed easily and promptly. It is possible in course of time when the responsibility for entry into all professions and occupations is handed over to their respective organisations and when every one follows his occupation not for personal benefit but as an act of social service, the proposal of the majority of the Committee may be safely adopted. That in Great Britain and in some other countries such power is given to the autonomous Medical Councils is not a convincing argument. Perhaps that may explain why even to-day the number of the medical personnel is inadequate for the need even in England.



## CHAPTER XXV

### EMPLOYMENT OF DEMOBILIZED PERSONNEL OF MILITARY HEALTH SERVICES

1. During the present war, the Indian Army has expanded more than 10 times its peace strength and, as a corollary, the military health and nursing services have undergone an expansion which, if not equivalent, is at least comparable to that of the executive branches. In addition to this phenomenal enlargement, the military medical services have undergone a radical reorganization and development dictated by the intensive application of modern science to military medical problems. The consequent medical progress has by no means been of purely military application, and the intensive development undergone has greatly increased the professional and technical value of the personnel concerned for civil purposes. When the history of the present war comes to be written by an impartial military historian, it is probable that a high place in the administrative achievements of the Allied arms will be given to the phenomenal development of the health services of the Army in India.

2. As a result, there exists in the medical and ancillary services of the Indian Army a great reservoir of personnel whose training and experience render them particularly suited to employment in the civil health services. This personnel comprises Medical Officers (male and female), Dental Officers, (I.A.D.C.), Nurses, and Technicians. We give here a short general description of each category and the civil employment for which they would appear to be suitable. A more detailed analysis is given in a tabular statement for which we are indebted to the Resettlement Section of the Office of the Director General, Indian Medical Service, and which is reproduced as Appendix 53.

#### I. Medical Officers (male & female)

3. This comprises:

- (a) Specialists "Recognized" and "Graded",
- (b) Graduates,
- (c) Licentiates with or without higher licentiate qualifications,
- (d) Nutrition Experts and
- (e) Blood Transfusion Officers.

##### (a) Specialists

4. Specialists are of two types—"Recognized" and "Graded". The subjects in which specialization is recognized cover practically the whole field of clinical and preventive medical science and include the related science of physiology. Amongst the "Recognized" Specialists are many who independently of their military "recognition" possess higher qualifications in their speciality and these officers are naturally marked out for higher teaching posts, specialist appointments on the staff of teaching hospitals, research work and the direction of institutes and/or units of their specialities. These remarks apply also to the Recognized Specialists without the higher qualifications and to the Graded Specialists, but the latter in most cases, and

in some cases the former, will require a further period of post-graduate study and training before being elected to the more senior and specialist civil posts. We are of opinion that, in view of the urgent need of the existing Medical Colleges, and of those to be created for teachers, the cases of officers from this class who are candidates for civil employ should receive a critical review by a selection committee composed of medical scientists of the highest eminence available and that special facilities should be afforded to individual officers, whom this committee may recommend, for the prosecution of appropriate post-graduate study in India or abroad.

(b) *Graduates*

5. This class comprises graduates of the various medical colleges in India some of whom have had experience and practice after graduation. All of them, however, have benefited by an intensive course of instruction in military and general medical science on their admission to the Service and have subsequently had the further advantage of working under specialist officers and consultants. The latter class include men of international reputation as teachers and practitioners of their specialities, ranking in ability with the highest authorities among the English-speaking people. With these advantages it follows that the medical graduate should, on the termination of his military service, have gained an experience and poise which would otherwise have been impossible. He will, moreover, have developed that preventive outlook which permeates the military medical services and which we consider to be essential for the Indian medical practitioner of the future. The natural avenues of civil employment for these officers are general duty in the primary and secondary units, school medical service, industrial medical service, special public health work, rural and urban.

(c) *Licentiatees with or without higher licentiate qualifications*

6. With the award of officer status in the Indian Army Medical Corps to licentiatees, the latter have taken their rightful place as fully qualified medical officers and have discharged duties in every respect identical with those of graduates. Many of this class, especially those with higher licentiate qualifications, have proved themselves at least the equal of the graduates, and have enjoyed, and fully profited by, the advantages and contacts which have been available to their graduate brother officers. They will emerge from military service as highly competent doctors with the poise and self-confidence that is born of commissioned status in a disciplined service, and their appropriate civil employment will be in the avenues mentioned for graduates without any distinction other than that dictated by individual ability and merit. The possession of higher licentiate qualifications will naturally lead to a more specialist civil employment in, say, Tropical Medicine or Hygiene.

7. It is probable, however, that many will wish to avail themselves of the facilities allowed by the Indian Medical Council, and recommended by it to the various universities, to proceed to a medical degree; and we recommend that every facility for this purpose should be granted by the existing medical colleges and those to be created.

(d) *Nutrition Experts*

8. These comprise both graduate and licentiate officers of the Indian Army Medical Corps who have served in military nutritional

units where a notable amount of original and valuable research work has been carried out. They will have acquired, in a special degree, the scientific approach to nutritional problems and their obvious location in civil employ is in public health organizations and the nutrition departments of universities, medical colleges and large hospitals and research laboratories. To those who are licentiates, our recommendations for facilities to proceed to graduation, apply with equal force.

(e) *Blood Transfusion Officers*

9. These again comprise both graduate and licentiate officers who have received special training and gained experience in military blood-transfusion units. The latter are highly organized and fully abreast of the latest developments of this science in which the civil health services are as yet notably deficient. It is necessary that considerably more attention should be given to the science of resuscitation in the larger civil hospitals, and there should be no lack of opportunities for employment of these officers in their resuscitation units.

**II. Dental Officers (officers of the I.A.D.C.)**

10. The officer cadre of this newly formed corps includes possessors of Western dental qualifications and those holding purely Indian diplomas. The latter are the product of the Indian dental schools and colleges enjoying recognition by the Governments of the provinces in which they are situated. These institutions have received attention in that part of our report which has dealt with the survey of existing conditions, and it is sufficient here to remark that they are of recent formation and have suffered from a scarcity of adequately qualified teaching talent. As a consequence, their qualifications do not yet carry that guarantee of full acquaintance with and proficiency in the latest developments of dental science which are implicit in the recognised Western standards.

11. In that section of our report which deals with professional education, we have emphasised the urgent need for the intensive development of dental education and the establishment forthwith of dental colleges for the purpose. It is on the staff of these new colleges that the officers of the Indian Army Dental Corps possessing Western dental qualifications will find their natural avenues of civil employment, while those possessing recognized Indian qualifications will find their civil outlet in appointments as dental officers in the various hospitals contemplated in our recommendations. Every facility should be given to such officers to proceed to the basic academic dental qualification which we have recommended.

12. It is, of course, contemplated that, eventually, there will be a dental surgeon associated with every primary unit, but this will be possible only when the number of qualified dental personnel has greatly increased. In the short-term programme, this provision must of necessity be restricted to the secondary health centres and the travelling dental clinics we have recommended.

**III. Nurses**

13. Included in this category are (1) fully trained women nurses of the temporary and reserve cadres of the Indian Military Nursing Service, the Auxiliary Indian Nursing Service, and of the Auxiliary Nursing Service, (2) fully trained male nurses registered by the Provincial Nursing Councils holding Viceroy's commissioned rank, (3) partially trained women nurses employed in the Auxiliary Nursing



Service, (4) partially trained male nurses (the so-called Specialist Improvers of the Indian Army Medical Corps (I.A.M.C.)), (5) general nursing orderlies of the Indian Army Medical Corps and (6) nursing orderlies with training in special conditions such as venereal and mental diseases, operation-room work etc., dental orderlies, and masseurs.

14. *Fully trained women nurses.*—In the survey section of our report we have drawn attention to the tragic scarcity of trained nurses in India and to the clamant need for their intensive production in large numbers. Existing training institutions must be re-organized and modernised and many new schools established. In the higher ranks of the military nursing services there are Nursing Officers of the Temporary and Reserve cadres who possess special training in and experience of nursing administration and teaching, and it is particularly from this source that the Nursing Superintendents and Sister Tutors of the civil medical schools should be drawn. For those trained women nurses, not possessing these qualifications and experience, ample avenues of employment will be found as ward sisters, staff nurses in hospitals and sanatoria, and in the nursing branches of the public health services which are in contemplation.

15. *Fully trained male nurses.*—These remarks apply with equal force to the fully trained male nurses whose numbers are so limited that it is not unlikely that the majority of them will elect to remain in the nursing services of the Army in view of the favourable terms and conditions offered by the latter.

16. *Partially trained nurses.*—As regards the various categories of partially trained and uncertificated nursing personnel, there are two main divisions (1) women of the Auxiliary Nursing Service and the male Specialist Improvers of the I.A.M.C., and (2) the various categories of nursing orderlies of the I.A.M.C. (1) The former division have received their instruction and training in English and, in the case of the Specialist Improvers at least, possess the basic educational qualification required for the senior certificated course which we have recommended. The majority of the Provincial Nursing Councils have recognised the military training and service as qualifying wholly or in part for the courses of training laid down by them; and it will be possible for the majority of this division, after a short period of extra probation and training in the nursing of conditions not covered by military nursing services and passing the requisite examinations, to obtain full certificated status in their native provinces. With the clamant need that exists for trained nurses in the health institutions we have recommended, we do not think there should be any difficulty in finding suitable employment after certification for all personnel of this division demobilized from the Army.

17. The second division nursing orderlies, consist of other ranks of the nursing section of the I.A.M.C. In the majority of cases their training has been in the vernacular and they have been unable during their service in the Army to obtain the necessary basic English educational qualifications. They generally possess, however, a high degree of nursing experience and competence, and are in every respect the equals of certificated nurses trained in the vernacular. We understand that the military authorities contemplate establishing a special vernacular nursing certificate for this class of personnel, and we recommend that the syllabus for this certificate should be

studied and, if approved, should be recognized as qualifying, wholly or in part, for the award of the status of junior certificated nurses which we have recommended elsewhere. The training and experience possessed by this class of other ranks is so valuable that we consider the time is long distant when experienced nurses of this class can be overlooked. In our opinion after further training, where necessary, in conditions not covered by military practice, they are fully entitled at least to the status and emoluments recommended for the junior certificated nurse, after passing the required examination.

18. As stated already the class under consideration comprises nursing orderlies with training and experience in special conditions. They will, therefore, prove of especial value in the staffing of corresponding civil institutions such as mental hospitals, clinics for venereal diseases, ophthalmic clinics, dental clinics and operating rooms.

19. For those who are unable even with further training to pass the requisite examination, but who, nevertheless, possess considerable nursing experience, as well as the selected members of those categories of personnel engaged by Provincial Governments for emergency duties in connection with famine or air-raid precautions who possess the minimum necessary educational qualifications, it will probably be necessary to create and register a class of Assistant Nurse i.e., personnel capable of nursing the sick under the supervision of fully qualified nurses. This measure has been found necessary in the United Kingdom with its comparative wealth of nursing personnel, and would seem inevitable in India with its extreme shortage, if the fullest possible use is to be made of persons possessing nursing experience.

20. *Masseurs*.—This is a class which is virtually non-existent in civil employ, and they will be readily absorbed in the orthopaedic units of the secondary and headquarters hospitals.

#### IV. Technicians

21. Trained technicians in the generally accepted sense of the term do not exist in civil life in India. It is true that in the laboratories of the various Government institutions there exist persons who by long training have acquired a high degree of competence in the special aspects of this field; but such persons are almost without exception lacking in the basic educational qualifications implicit in the term 'technician' and have acquired their competence by natural intelligence and through long practice. Their number is so small in relation to the need for trained technicians as to be negligible and the class in question may be said to exist solely in the Indian Army Medical Corps. They comprise Radiographers, Laboratory Assistants and Dispensers, and for sometime to come, until technological education in India has undergone the expansion and development which modern conditions require, it is mainly from this class of military personnel that the civil needs must, in the short period, be met.

22. In the foregoing paragraphs we have given a brief review of the classes of medical and ancillary personnel which are likely to be available for civil employment after demobilization. We understand that the Government of India are already collecting and classifying particulars of all these classes and also of special formations such as Anti-Malaria Units with a view to notifying Provincial Governments as to the number of persons under each class who may be

residents of the province concerned and who will be available on demobilization. We further understand that Medical Resettlement Committees for the purpose of "placing" this personnel in civil employment are under formation or in contemplation in each province and administration. We suggest that representatives of the Indian Medical Association and the Licentiate Medical Association should be included in such Committees in the Provinces and at the Centre. We welcome these proposals and would emphasise the necessity of their receiving the constant and unremitting attention of the authorities concerned both military and civil, in order that this reservoir of trained talent may be available to the fullest possible extent to the health services of the country. If this opportunity of providing trained personnel for the carrying out of our proposals is allowed to pass without full advantage being taken of it, it may materially delay the initiation of the nation-wide health service for the country which we contemplate. We, therefore, consider it essential that the services of all such personnel should be utilised, except in cases of proved unsuitability.

23. Four of our colleagues (Drs. Vishwanath and Butt, General Hance and Sir Frederick James) desire to lay special emphasis on the remobilisation for civil purposes of demobilized medical and ancillary personnel and their note is appended.

**A Note on Employment of personnel demobilized by the Army by Dr. Vishwanath, Dr. A. H. Butt, Lt.-General J. B. Hance and Sir Frederick James.**

We have emphasised from time to time in this report the total inadequacy of doctors, nurses and medical technicians of all kinds. Our proposals involve great increases in all categories. This is bound to take time, and therefore, in the meantime, all available resources should be tapped. With the end of the war many doctors, nurses, etc., will face demobilisation. In our view it is essential, having regard to the urgency of the health problems in India, that no one whether doctor, nurse, or medical technician, should on demobilisation be faced with even temporary unemployment. In fact we believe that, to the extent to which it is practically possible, those who are now being demobilised should at once be remobilised by the Governments concerned for peace-time employment in India's medical and health services. Both medical relief and preventive medicine have been practised at their best in the Indian army, navy and air force. The experience and training acquired through military medical service is equal, if not superior to, any courses which the Governments may provide for the medical cadres of the future. We therefore consider it important that the employment of every member of the medical personnel and health services now being demobilized, except in cases of proved unsuitability, should be secured for the civil medical and health services in the country. This will require close co-ordination between the military authorities and the civil governments and, above all, an assurance of security of employment subject of course to continued competence. We understand that steps are being taken in this direction, but we desire to see these fully and immediately implemented and made as widely known as possible.

## CHAPTER XXVI

### THE ESTABLISHMENT OF A COMMITTEE OF STANDARDS FOR MEDICAL INSTITUTIONS AND EQUIPMENT.

1. In view of the heavy constructional programme which will have to be formulated to supply the new accommodation required by our proposals, as well as for structural alterations to existing buildings and for the supply of a vast number of fittings of all kinds to laboratories, health centres, hospitals etc., it seems desirable that some system of standardization should be evolved which will introduce order into what may otherwise well tend to become chaos. With the achievement of order there will be obtained the further advantage of reduced cost that automatically accompanies effective standardization.

2. Sigerist in his "Socialized Medicine in the Soviet Union" tells us that, included among the 20 Standing Committees covering the various medical specialities in the Medical Council of the Commissariat of Health, is a large Committee on standards whose function it is to make typical plans for the construction of hospitals, standardization of equipment etc.

3. We urge the setting up of such a Committee in India and suggest that it should be closely linked with the appropriate section in the Central Ministry of Health. It seems to us that this Committee will, at least in the initial stages, have to be more or less in permanent session.

We feel that for a committee of this nature to be really effective it is essential that it should not be overburdened by the inclusion of a number of highly placed officials who have no special knowledge of, or interest in, the problems which will be presented for solution. It should above all be a technical working Committee reporting to and advising the Directorate of Health on questions relating to construction and design.

4. The following suggestions in regard to its composition are put forward. It should include:—

(1) architects with experience of designing, and construction of, medical institutions under tropical conditions;

(2) engineers with similar experience;

(3) medical practitioners, not merely as doctors, but as having an interest in, and experience of, design, construction and administration of medical institutions;

(4) laboratory scientists with an interest in the elaboration of laboratory fittings on a transferable unit system and

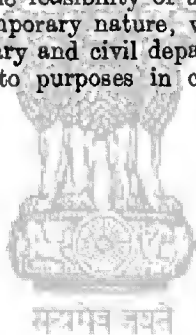
(5) members of the nursing profession with a special knowledge of the problems of internal hospital design.

5. In order that breadth of vision may be given to the work of the Committee, it is suggested that a prominent architect should be engaged for a period of two years to preside over its deliberations, the choice to be guided chiefly by the architect's acquaintance with modern trends in Europe and America. Hospital and institutional

design is a highly specialized type of architectural practice and one of which there are few exponents in India. There is, therefore, a danger that, without really up to date guidance, hospitals may in some cases be erected which are years behind the times. We feel that it is not sufficient to rely entirely upon architects with local experience for the work which will be required. Although the special experience of the latter will be invaluable in carrying into execution the actual drawing up of type plans, the guidance of a mature and widely experienced mind will undoubtedly be of the greatest benefit to them during the early stages.

6. We are aware that it will not always be possible to produce formal type plans of general application for a sub-continent such as India. Questions of siting, of climate, or the prevailing wind, of soil etc., cannot be answered on a universal basis. Nevertheless we feel that the broad principles of design for different types of medical institutions are capable of a large degree of standardisation, which would also serve to secure a reduction in cost and speed in construction.

7. We advise that the Committee, when formed, should give serious consideration to the feasibility of adapting some of the many existing buildings of a temporary nature, which have been set up for war purposes by the military and civil departments of the Central and Provincial Governments, to purposes in connection with our health development programme.



## CHAPTER XXVII

### RE-EMPLOYMENT OF PERSONS WHO HAVE REACHED THE AGE OF SUPERANNUATION

1. Among the major difficulties which have to be overcome in the successful implementation of our recommendations probably the greatest is the general inadequacy of existing health personnel and, in some cases, the entire absence of certain classes of professional and technical workers. Whether it be doctors who are concerned or nurses, health visitors, midwives, pharmacists or dentists, the numbers available in India in relation to the population to be served fall far short of the standards considered desirable in the more advanced countries of Europe and America.

2. In the majority of services under the control of the Central and Provincial Governments it is the normal rule that Government servants are superannuated at the age of 55. It seems to us that the need for trained personnel is so clamant as to make the rigid maintenance of this practice inconsistent with the requirements of the situation, at any rate throughout the short-term period and probably in the earlier years of the succeeding period.

3. We are, however, anxious to ensure that the retention of persons in service after reaching the age of superannuation should not stand in the way of normal promotions in the service. Nor should any person continue to be employed after reaching the prescribed age limit unless he is considered fit, physically and mentally, to carry on his duties and unless his continuance is considered to be in the public interest. We therefore make the following recommendations:

(i) Such persons should be made to retire before they are re-employed.

(ii) The officer concerned should be brought before a medical board with a view to establishing his physical fitness for further Government service, either in the capacity in which he was employed on reaching the age of superannuation or in any other capacity that Government may ordain. If found physically and mentally fit, his services should be retained on a year to year basis, subject to annual examination by the medical board.

(iii) We desire to ensure uniformity in emoluments for all officers who are thus re-employed. We therefore recommend that, in every case, the pension drawn by the officer should be supplemented in such a way as to make his total emoluments not less than those he enjoyed at the time of superannuation.

(iv) It should be one of the conditions of such re-employment that the persons concerned will be required to serve in any capacity that Government may deem fit.

(v) Normally such extensions of service should not go beyond the age of 60; but in any special case, where the officer is considered to be of exceptional ability, extension may be granted up to the age of 65.

(vi) We recommend that this rule should apply to all members of the health services.

## CHAPTER XXVIII

### THE POPULATION PROBLEM

#### Introduction

1. The steady growth of population, which has taken place in India during the past few decades, has had its repercussion on all such matters as the housing, clothing and feeding of the additional numbers brought into existence from year to year, their education and the provision of adequate measures for the protection of their health. No programme of social reconstruction can, therefore, afford to ignore the implications of the population problem. Although a detailed examination of the subject falls beyond the scope of our investigations, a reference to this important subject seems essential because, in a comprehensive survey of the factors which have a bearing on the health of the community, the question of the need for a continuous adjustment between the population and the resources that are available cannot be ignored and should receive serious consideration.

#### A Review of the Existing Position

2. The earliest systematic enumeration of the people in India was carried out in different parts of the country between 1865 and 1872. The first synchronous census took place in 1881 and since that year decennial enumerations have been made. The rates of increase during the inter-censal periods have shown considerable variation as will be seen from the following figures:—

#### *India—percentage rates of inter-censal increase*

Period	Ratio of increase Per cent
1872-1881 . . . . .	1.5
1881-1891 . . . . .	9.6
1891-1901 . . . . .	1.4
1901-1911 . . . . .	6.4
1911-1921 . . . . .	1.2
1921-1931 . . . . .	10.6
1931-1941 . . . . .	13.6

3. During certain inter-censal periods the rate of growth was extremely small. In the two periods, 1872-1881 and 1891-1901, widespread famines were responsible for the low rates of increase. It has been estimated that, between 1875 and 1900, about 23.74 million deaths took place as the result of famines alone. The pandemic of influenza during 1918-19 was responsible for the low rate of increase (1.2 per cent.) recorded during the period 1911-21. As regards disease, during the first three decades of the present century, cholera deaths totalled nearly 10.75 millions in British India alone while the influenza epidemic of 1918-19 is said to have been responsible for about 14 million deaths in India as a whole. Since its introduction into Bombay in 1896 plague has caused about 13 million deaths in the country. The mortality due directly to malaria is estimated to be at least one million each year. The history of the growth of population in India, therefore, seems to illustrate the contention of

Malthus that disease and famine impose checks on an unlimited growth of population.

4. After 1921 there has been, on the other hand, a steady growth of population in the country. The main reason for this continuous increase during the two inter-censal periods has been an appreciable fall in the mortality rate as will be seen from the figures given below :—

Year	Birth rate per mille	Death rate per mille	Annual excess of births over deaths
1891-1900 . . . . .	33	31	512,277
1901-1910 . . . . .	37	33	933,623
1911-1920 . . . . .	37	34	667,654
1921-1930 . . . . .	33	25	1,995,301
1931 . . . . .	35	25	2,409,846
1932 . . . . .	34	22	3,122,374
1933 . . . . .	36	23	3,447,582
1934 . . . . .	34	25	2,316,472
1935 . . . . .	35	24	2,967,445
1936 . . . . .	36	23	3,455,021
1937 . . . . .	35	22	3,276,082
1938 . . . . .	34	24	2,712,891
1939 . . . . .	34	22	3,180,911
1940 . . . . .	33	22	3,161,376
1941 . . . . .	32	22	3,012,729

It will be observed that, while the birth rate has shown no appreciable decline during the period, the decrease in the death rate, particularly during 1921-41, has been more marked. While these rates, which are based on recorded figures for births and deaths, undoubtedly suffer from a degree of incompleteness of registration which cannot be correctly estimated, they serve to show the trend of fertility and mortality during the period covered by them. Later in this chapter, we have quoted certain estimates of fertility and mortality for the same period, which have been calculated on a different basis, and these also indicate the same trend.

5. The total increase of India's population between 1872 and 1941 was about 54 per cent. while, during the same period, the corresponding rates of increase for the United Kingdom and for Japan were 35 and 136 per cent. respectively.\* Therefore, India's rate of growth cannot be considered to have been extraordinarily high. Even during the period of highest increase (1921-41) the yearly rate was under

\* "Demographic Fact and Policy in India" by Kingsley Davis, published in the Milbank Memorial Fund Quarterly (July 1944).



1.5 per cent., while it has been the experience in more than one community that, under favourable conditions, the population doubled itself in about 20 to 25 years, which gives an average rate of growth of 4 to 5 per cent. per year. Although the rate of growth in India is smaller, the massiveness of her population has made the absolute increase a figure of considerable magnitude. For instance, during the 20 years from 1921-1941, she added 83 millions to her population. What is important, therefore, is not merely the rate of growth but the huge additions to population which are bound to have their repercussion on the existing low standard of living.

### **The Importance of Population Estimates from the Point of View of Planning**

6. From the point of view of planning for the future, whether it be in the field of health administration or in other fields, a forecast of the probable population of the country, including its age and sex composition, during the period which is likely to be covered by the post-war development plans under consideration, is eminently desirable. This forecast is essential in order to provide a reasonably sound basis for estimating such fundamental requirements of the community as food, water-supply and housing while estimates of health and other services should also be related to the population to be served.

7. It is unfortunate that the Government of India decided that the information regarding age, which was collected during the 1941 census, need not be tabulated at the time. Since then various causes arising partly out of the War have made it impossible to tabulate the original data collected at the census. The age and sex composition of a community is fundamental to any investigation regarding the growth of population. In 1944 the Government of India attempted to rectify its mistake by appointing a Population Data Committee to examine and advise Government on the available data relating to the growth of population. This Committee has made certain recommendations which, if followed, will make it possible to construct an age and sex table for the country. When this work is accomplished it may be expected that a forecast of the probable increase of population during the next 20 or 30 years will be made available. In the meantime, we may investigate whether any light can be thrown on the probable trend of the growth of population in India.

### **The Probable Trend of the growth of Population in India**

8. The three main factors which influence the growth of population are (1) migration, (2) mortality and (3) fertility.

#### **Migration**

9. The effect of migration on India's population has been negligible for sometime past and is likely to be so, at least for some time longer. This is due to the restrictions which the Governments of other countries have placed on the entry of Indians into their territories. India's total loss by migration within the period between 1921 and 1931 was about a million and three quarters, a figure which is insignificant in comparison with the total population of the country. We may, therefore, leave migration out of consideration in our discussion of the probable trend of population growth in the country.

#### **Trend of Mortality and Fertility Rates**

10. In an interesting study of India's population problem, under the title of "Demographic Fact and Policy in India" published in

the Milbank Memorial Quarterly (July 1944) Kingsley Davis has attempted to compare India's rates of fertility and mortality over a period of several decades. Both these rates are based on the assumption that census enumerations are more accurate than recorded birth and death statistics. The fertility rates have been calculated by what is known as the "reverse survival" method, which utilises an appropriate life-table to estimate the births during each year of an inter-censal period which, at current survival rates, would give rise to the children aged 0-9 enumerated at the census at the end of that period. The average decennial death rates were calculated by subtracting the inter-censal increase from the estimated births for each decade. His estimates of fertility and mortality rates are given below:—

Year	Estimated	
	Fertility rate	Death rate
1881-1891 . . . . .	49	41
1891-1901 . . . . .	46	44
1901-1911 . . . . .	49	43
1911-1921 . . . . .	48	47
1921-1931 . . . . .	46	36
1931-1941 . . . . .	45	31

These rates also confirm the view which has already been advanced, namely, that the fertility rate has practically remained stationary during the period under consideration, while the death rate declined appreciably between the years 1921 and 1941.

11. The probable trend of the growth of population in India will be determined by the changes that are likely to take place in the death and birth rates in the immediate future.

#### Death Rate

12. A further fall in the death rate is bound to occur if the large scale programmes for unproving the life of the community advocated by the different post-war planning committees are effectively put into operation. If the birth rate continues at about the existing level, the resulting annual increase in population will be higher than in the past. To indicate the comparatively large increase that may result from a reduction of the mortality of one section of the population alone, we may refer to the interesting note of Mr. Satya Swaroop in the Census of India, Volume I, 1941, in which he has attempted to assess the probable effect of a saving of infant life on the growth of India's population at the censuses of 1951 and 1961. On the assumption that the rate of fall in infant mortality between 1921 and 1941 would be continued, he calculated that in 1960 the infantile death rate would be 192 per 1000 live births. In view of the fact that, in certain countries, the rate has already been reduced to half this figure, it seems almost certain that, if a proper health programme is developed, the infant mortality rate in India in 1960 will be

appreciably lower than 132. Mr. Swaroop has shown that, in 1951, the total increase in population resulting from this cause alone will be in the neighbourhood of 7 millions and, in 1961, about 13.4 millions. From our survey of existing morbidity and mortality in India in the appropriate sections of this report, it will be seen that at least one half of the existing annual mortality of over six millions in the country is preventible. If our proposals are carried out, there is every reason to believe that there will be a saving of at least three million lives every year in British India, which will bring its rate of mortality down to the level of what has already been accomplished in a number of other countries. In the decennium between 1931 and 1941 the average yearly addition to the population of India as a whole was five millions. An annual saving of three millions in British India as the result of improved health administration will raise India's rate of growth to 8 millions a year, without taking into consideration any fall in mortality that may be brought about in the Indian States through similar health measures. Under such conditions the very large increase of 83 millions, which took place in the 20-year period between 1921 and 1941, is likely to be reached within half that time. A purposeful control of mortality, without a corresponding fall in the fertility rate of the community, can thus have far-reaching consequences.

### **Fertility**

13. The rate of decrease in fertility tends to lag behind that of mortality. This was the reason why in the 19th century when a better standard of living and improved health services brought about a marked fall in the death rate, there was a remarkable increase in the population of Europe. In the article referred to above, Kingsley Davis has offered an explanation for this interval between the starting of the fall in mortality and that in fertility. He states that "both reproduction and the preservation of life are indispensable for the continuance of any society, and therefore, through socialisation, are instilled as profound values in the minds of each new generation. It follows that with the coming of a more deliberate, innovative control over human affairs, a movement to limit fertility in unaccustomed ways will meet strong opposition as being contrary to an established value, whereas attempts to preserve life, even in unaccustomed ways, will meet with approval as being in favour of an established value. It is only after the successful preservation of life has resulted in large families and these large families have proved an embarrassment to the individual in the highly urbanised and mobile structure of modern society, that he seeks a way around the full practice of his high fertility mores. He leaves the customary evaluation intact, but tends to violate it to a certain degree in his own private behaviour. Thus the lag of birth control behind death control is implicit in the growing rationalism of modern life, which first attacks the negative value (death), and only later the positive value (high fertility)."

14. India is far behind western countries in respect of both urbanisation and modernisation. The consequence is that the motive force behind the movement for limiting the size of the family does not operate in respect of large sections of the population. We believe that, among the working classes, the position is quite the reverse. Children are often employed at a comparatively tender age and,

therefore, begin to be of help to their parents. This state of affairs militates against the possibility of volitional control over the growth of the family.

15. Until the economic condition of these sections of the community is raised appreciably, it seems most unlikely that there will arise the desire to restrict the number of the offspring to what the parents consider desirable, in order to ensure a reasonable standard of living for themselves and their children. We have no doubt that the post-war plans for national development will ultimately achieve this end and that India will witness, as in the case of other countries, a definite fall in the fertility rate as the result of purposeful family limitation by individual parents. But before this stage is reached we feel that the immediate effect of measures designed to reduce mortality may well be to increase the rate of growth of population in the country.

16. Certain other factors, which have a bearing on fertility, are early marriage, the proportion of married women in the community and prohibition of widow remarriage. Marriage is almost universal among women in this country and the large majority of them are married fairly early in life. While it is true that a gradual rise in the average age for marriage in respect of girls is noticeable among the upper middle and richer classes in the community, it is doubtful whether such a tendency is likely to become operative, in the near future, among the population as a whole. A change in the social outlook, which will be necessary to promote a general raising of the age of marriage for girls, can take place only slowly. Of the total reproductive period for women, which may roughly be taken as 15 to 45 years, it has been shown by carefully collected statistics from many countries that the most fertile period is from 15 to 19 years; and that the fertility rate grows steadily smaller thereafter. The high proportion of married women in the country and the early age at which they marry must, therefore, be considered as factors favouring a persistence of the present rate of fertility.

17. The existing prohibition of remarriage of widows among large sections of the community helps, in some measure, to check the growth of population. It must, however, be remembered that the present rate of fertility has been maintained in spite of such restrictions. Assuming, on the other hand, that a change in social outlook relaxed the ban on their remarriage, the effect will be to raise the fertility rate. Kingsley Davis has estimated that if "the proportion of widowed women in India becomes as low as it was in the United States in 1930 there would be a net gain of 14 per cent. in fertility." An improvement of maternal health and the consequent reduction of sterility, that may result from the operation of the proposed health programme, will prove to be another contributory factor in increasing the reproductive capacity of women.

18. It would thus seem fairly clear that, at least in the immediate future, there is little reason to believe that there would be a marked fall in the fertility rate of the country.

19. Within the last few years a marked fall in the birth-rate and a definite rise in the death-rate have been noticeable in a number of provinces. Causes arising out of the War are most likely to have been largely associated with these departures from the normal trends

of these rates discussed above and, until further evidence is available, it is difficult to believe that, with the return of more settled conditions, the reduced rate of growth of population which the war-time rates suggest, will continue.

20. In the circumstances indicated above, we may safely conclude that, in the near future at least, the probable trend of population will be in the direction of an accelerated rate of growth.

### OUR RECOMMENDATIONS

21. It is our considered opinion, in view of what has been said, that in the absence of certain natural checks such as famine and disease whose operation will, speaking generally, become more and more limited as our various programmes of social security and improvement in living conditions develop, the growth of population in India will become an increasingly serious problem. We have therefore felt it necessary to set forth its implications and to suggest certain lines on which its solution may be attempted.

22. Growth of population may be prevented from becoming a serious menace to the standard of life of the community in the following ways:—

- (a) by emigration;
- (b) by increasing the production of national resources and
- (c) by a reduction in the rate of additions to population.

#### Emigration

23. We have already pointed out that the prospects of emigration helping to lessen the pressure of population on the means of subsistence in the country appear to be remote. While we consider it wholly unjustifiable that Indians should be excluded from certain large empty or sparsely populated spaces on purely racial grounds, we can suggest no practical means, which are likely to bear fruit in the foreseeable future, for removing these impediments. Prejudices die hard and what may seem worthy of condemnation in others may often be transmuted into a virtue if practised by ourselves.

#### Increase of Production

24. We recognise that the advance of science, careful planning and concentrated effort on the part of the community to develop the country's resources may make possible the support of a largely increased population on even a better standard of living than that which exists at present. We feel, however, that such measures can constitute only a temporary expedient, because a limit to economic productivity will be reached, sooner or later, and uncontrolled growth of population must, as far as we can see, outstrip the productive capacity of the country.

#### Reduction in the Rate of Additions to Population

25. A reduction in the rate of growth of population may be brought about by permitting the death rate in the community to rise. Our social instincts militate against this. A noticeable feature of social evolution has been a growing recognition of the need for the rigorous enforcement of measures intended to conserve life and to promote human happiness. One of the objectives universally

accepted in all civilised countries is a reduction of morbidity and mortality in the community. We have, therefore, to turn to other means for decreasing the rate of growth of the population. They may be considered under three heads, (1) a raising of the age of marriage for girls, (2) an improvement in the standard of living and (3) intentional limitation of families.

### **(1) Raising of the Age of Marriage for Girls**

26. Carefully collected statistics from several countries support the view that the fertility of women is at its highest during the age period 15 to 19. The raising of the age of marriage for girls by a few years from the present minimum of 14 would probably effect a reduction in the birth rate. It will be remembered that in 1929 the Sarda Act, which raised the minimum age of marriage to 14 years, produced a storm of protest in the country. Although there has been a considerable liberalisation of public opinion towards this question since then, there is likely to be similar and perhaps stronger opposition to any further considerable increase in the age limit. Legislation, which is too much in advance of what the people are willing to accept, tends to be ineffective and often unworkable. At the same time, it should be the function of popular Governments to educate public opinion and persuade the people to support such legislation and administrative measures as are designed to promote the public good. There are strong physiological reasons for raising the minimum age for the marriage of girls to 16, 17 or even 18.

27. We refrain, however, from making a specific suggestion, partly because we are not unanimous on the point, and partly because we feel that the question is so intimately bound up with social custom and tradition, that the Governments concerned should consider the state of public opinion before taking any decision.

### **(2) Improvement in the Standard of Living**

28. An improvement in the standard of living generally tends to promote a lowering of the birth-rate by helping to create an incentive in individuals to limit the size of their families in the interests of maintaining for themselves and their children a reasonable level of comfort and of enabling the latter, through proper education and through the opportunities for earning their living which such education offers, to keep up the standard of life to which they had been accustomed. This improvement in living standards can be brought about only through the mobilisation, to the fullest possible extent, of the community's human wealth by measures designed to promote the health and working capacity of the individual as well as of the material resources available in the country. The steps that are now being proposed for the reconstruction of national life have these two purposes in view and are, therefore, of the greatest importance from the standpoint of promoting a steady rise in the standard of life of the people. Such rise must, however, be a slow process. It implies, besides the creation and functioning of the requisite machinery for developing the country's national wealth, the education of the people in new modes of life and to an appreciation of values to which they have so far been unaccustomed. While this development goes on, it seems more than likely that such active measures as the proposed health services will introduce will result in an

appreciable reduction of the death-rate and thus produce a temporary acceleration of the rate of growth of population.

### (3) Intentional Limitation of Families

29. If we believe that limitation of families is advisable, we should first ask ourselves the question whether it is possible that this could be secured through self-control. Our answer must be, we fear, not to any material extent. A limited number of individuals may be under-sexed or may, by nature, be so constituted that they can sublimate most of their sexual urge into intellectual, artistic or other creative channels. But the large majority of mankind, while they may be able to convert a part of their sexual impulse into activities useful to the community, will still have to find satisfaction in the sexual act itself. This seems to us only natural because the sexual instinct is one of the strongest instincts in men and animals, serving as it does, to ensure the continuance of the species. Further, it is likely that an undue repression of the sexual desire may affect the individual's health, because it involves the intentional suppression of a normal physiological instinct. In the circumstances, we seem to be left with birth control through positive means as the only method which is likely to be effective.

#### Arguments in favour of Birth Control

(1) Intentional control of the size of the family is not without precedent in the history of human communities. Limitation of families has been practised by such communities from time immemorial and the studies of students of the population problem have established various practices such as infanticide, abortion, religious prohibition of sexual intercourse during stated periods and prolonged lactation as some of the methods that primitive communities have practised for the purpose. The modern birth control movement differs from the older ones in that the methods now practised are safer and permit of wide adoption without offending generally accepted ethical standards.

(2) When childbearing is likely to result in injury to the mother or the child, the practice of contraception needs no justification. Childbearing, although it is a normal physiological function in the case of healthy women, causes an undue strain on those who suffer from certain diseases. For instance, tuberculosis, heart disease, diabetes, chronic nephritis and others may so devitalise a woman that the added strain of pregnancy and childbirth may cause grave damage to her health and even endanger her life. There are also many conditions of abnormal health in the mother that may adversely effect the child in the prenatal stage. The prevention of conception will, in these cases, result in infants, with a small chance of survival, not being brought into existence. Further, apart from any specific disease in the mother, continued childbearing with little or no interval between successive pregnancies may itself constitute an undue strain on her physical condition and spacing of births, so as to allow of a return to normal health, may prove to be a definite necessity.

(3) Parents can hardly control the complex socio-economic environment in which they live and, if they decide to have only as many children as they can bring up under what they consider to be reasonable standards of life, it is doubtful whether they can be

blained. Parents would, therefore, seem to have the right to demand that the State should provide suitable instruction to enable them to adopt family planning.

(4) It does not seem unreasonable to anticipate that, in India, women of the upper and middle classes are likely to attain a considerable degree of social emancipation in the not distant future. There will, therefore, be before them a widened horizon of opportunities for self-expression in professional and other fields. Such women are likely to refuse to adopt the drudgery of continuous child-bearing. Since the intelligent participation of women in the intellectual and social life of the community should be welcome, wise family planning would seem to be essential in order to give women time and opportunity for activities outside their home.

### **Arguments against Contraception**

(1) The deliberate dissemination of knowledge regarding birth control will remove one of the major deterrents to promiscuity, which is the fear that pregnancy will result. A further danger resulting from promiscuity is that of the spread of venereal diseases. Contraceptive methods do not provide a sure safeguard against the spread of such infection and the general use of contraceptives may be fraught with serious consequences to the community.

(2) Conduct divorced from responsibility injures the individual and the community. Whatever progress man has made in the organisation of civilised life has been through the continuous fostering of a sense of responsibility for the actions of individuals and of groups in relation to other individuals and groups. A deliberate attempt to produce conditions which will eliminate or weaken this sense of responsibility should be undertaken only after the most serious consideration has been given to all the consequences that may be expected. For example, there is the danger that the opportunities which contraception provides for pre-marital and extra-marital sex relationships may seriously threaten the sanctity of home life, to the detriment not only of the parents but also of the children.

(3) Birth control practised during married life is often based on the desire to maintain certain standards of life. This desire may, not infrequently, lead to people preferring a Baby Austin to a baby. If such a practice becomes widespread, the consequences to the State may be serious through the failure to ensure the maintenance of its population in adequate numbers and at the age levels which are calculated to secure maximum productivity. This danger seems, however, to be relatively remote as regards India.

(4) There are many to whom an interference with nature's processes appears repugnant.

(5) It is at least doubtful whether a contraceptive, which is both efficient and safe, has yet been discovered. Numerous contraceptives are widely advertised and used, but their effects on the woman as the result of prolonged use have not been fully investigated and determined. Before the use of contraceptives is actively promoted, it seems essential to ensure that those made available to the people are harmless.

(6) A birth control campaign has certain inherent dangers, which arise from the likelihood of the use of contraceptives being indulged in



more extensively by certain groups of the population than by others. The reason for the practice of birth control is often the desire of parents to provide for themselves and their children in their turn a reasonably high standard of life. Contraceptive practices are, therefore, more likely to be used by the more successful and intelligent sections of the community than by those who are improvident and mentally weak. It may also be mentioned that a certain number of defects and diseases are known to be heritable. These include congenital blindness, congenital colour blindness and congenital deafness, haemophilia (bleeder's disease, an abnormal tendency to bleed), certain abnormalities of the nervous system and some forms of mental disorder. The classes which possess many of these undesirable characteristics are known to be generally improvident and prolific. A continued high birth-rate among these classes, if accompanied by a marked fall in the rate of growth of the more energetic, intelligent and ambitious sections of the population, which make much the largest contribution to the prosperity of the country, may be fraught with serious consequences to national welfare.

#### **The Extent to which the State should help to promote the Birth Control Movement**

30. Having set out the arguments for and against the practice of birth control we may now consider how far Governments should help to promote the birth control movement. All of us are agreed that, when childbearing is likely to result in injury to mother or infant, there is every justification for the practice of contraception. In such cases it should be the responsibility of Governments to provide instruction regarding contraception in maternity and child welfare centres, dispensaries, hospitals and any other public institutions which administer medical aid to women. We also consider that the supply of contraceptive requisites should be made, free of cost, by the State to necessitous women when the practice is advocated for reasons of health. There is also unanimity among us in respect of State action in two other directions, namely, (1) control over the manufacture and sale of contraceptives as in the case of food and drugs and (2) assistance from public funds towards research for the production of a safe and effective contraceptive.

31. Some of us are of the opinion that, on economic grounds also, contraception is justified in the interests of the individual and of the community and that the State should provide facilities for imparting knowledge regarding birth control when desired for such reasons. The others, while they fully appreciate the importance of relating population to the economic resources of the country, feel that the active promotion by the State of contraceptive practices for economic reasons will be justified, in view of objections to it on religious grounds in certain quarters, only if there is substantial support from public opinion.

#### **Practical Difficulties in any large scale Extension of Birth Control**

32. In promoting birth control certain serious difficulties will have to be surmounted. Some of them are:—

(1) the large majority of women are not sufficiently educated to be able to learn and practice contraception satisfactorily;

(2) the people are so poor that the cost of placing a safe and effective contraceptive within their reach will be enormous;

(3) birth control knowledge will have to be imparted to the women of India by women doctors or health visitors and, as the total number of such personnel in the whole country is at present about 2,000, this is an impediment of considerable importance and

(4) certain communities look with disfavour on contraception for religious reasons.

### **The Extent to which the Proposed Measures are likely to Restrict the Growth of Population**

33. For the reasons indicated above a rapid extension of the birth control movement among the people, so as to provide an effective check on the rate of growth of population, seems to us unlikely in the immediate future. There also appears to us to be little immediate prospect of raising the age of marriage for girls by legal enforcement. A period of widespread educational work among the people, in order to convince them of the desirability of its adoption for health and social reasons, will have to precede any such action. On the other hand, as has already been pointed out, the immediate prospect is that, with the introduction of the proposed health services and of the measures designed to advance the welfare of the community, the rate of growth of population may show an acceleration as compared with the past. While recognising fully the implications of this increase in population we feel that the only practical steps that can be taken are (1) a relentless pursuit of the measures that are now being proposed for the reconstruction of national life in order to raise the standard of living and (2) the spreading of the knowledge of birth control as far as the limitations imposed by the peculiar circumstances of the country, to which we have referred, will permit.

### **Genetics and Population Policy**

34. The application of knowledge regarding heredity for the development of a healthy and vigorous stock of different species of animals and plants has been made by man with remarkable success in respect of many forms of life. Evidently, a constructive population policy must include within its scope the investigation of the possible methods of improving the future composition of the community by the application of knowledge regarding heredity. Such a policy would presuppose adequate information regarding the mechanism of transmission of desirable physical and mental characteristics as well as of those which should be eliminated. While geneticists have ascertained, in some detail, the ways in which certain defects are inherited, it seems correct to state that, in the wide field of inherited disease and defect, the interplay of both hereditary and environmental factors is of great importance and that, with the existing knowledge, it is difficult to separate their effects. Further "far too little is known about the inheritance of human temperament, physique or even intelligence."\* A pre-requisite to the formulation and execution of an effective population policy directed to promote the creation of a healthy and well-endowed community is, therefore, the accumulation of adequate knowledge

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\* Report on the British Health Services (1937), published by PEP (Political and Economic Planning).

regarding the hereditary and environmental aspects of the development of man's physical and mental characteristics. In the meantime, in some countries, particularly in the United States, laws have been in existence for some time for restricting the reproduction of the unfit by sterilisation. In England, on the other hand, the approach towards this problem has been much more cautious. "The Departmental Committee on Sterilisation in 1933, after a very thorough consideration of the case, recommended that legislation should be introduced to make legal the voluntary sterilisation of persons with a definite hereditary disease or defect, and they also considered that, with very strict safeguards, this legislation should be extended to "carriers of these diseases."\* In India, so little is known about the distribution of inborn defects in the population that it appears to us premature to attempt any such legislation at present. We believe, at the same time, that it is desirable, as a part of the study of the population problem in India, that the part which heredity plays in the transmission of valuable human traits and of defects should be investigated.

### **Study of the Population Problem**

35. In the chapter containing our recommendations regarding vital statistics we have suggested that the Registrar General at the Centre and the Provincial Registrars should publish annual reports on the population of British India and of the Provinces as the case may be, incorporating in them such information as is available regarding existing conditions and possible tendencies pertaining thereto. We consider it highly desirable that the population problem should be the subject of continuous study. Apart from the probable trend of population growth, such matters as differential fertility and mortality rates and surveys of morbidity among the various sections of the community are of interest and importance from the point of view of sound administration. The problems of heredity and environment in relation to population policy should also receive consideration. Such studies will have to include investigations "in the laboratory and in the field to explore the causes and antecedents of mental and other defects, and generally to examine fundamental factors affecting the composition and characters of the population".

36. We consider that such studies should be organised and conducted on as broad a basis of collaboration as possible. The Registrar General and the Provincial Registrars, with their respective staffs of trained statisticians, the Health Departments, Central and Provincial, and the Departments of Economics, Sociology, Statistics and Genetics in our universities, wherever such exist, should participate, in our view, in these studies.

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\* Report on the British Health Services (1937), published by PEP (Political and Economic Planning).

## CHAPTER XXIX

### ALCOHOL IN RELATION TO HEALTH

#### Introduction

1. The subject of alcohol consumption can hardly be discussed without giving rise to sharp differences of opinion. On the one hand there is a school of thought which considers that its use should be prohibited in the interests of the individual and of the community. Its consumption, except in strict moderation, may damage the health of the individual, reduce his working capacity and thus affect adversely the economic condition of himself and of those dependent on him. It is urged that total prohibition is in the interests of the individual and of society, because the excessive use of alcohol is often associated with violations of public decency and with anti-social acts such as neglect of family obligations and crimes of violence, while the proportion of those who can exercise sufficient control over themselves and limit its use to such moderate amounts as will not cause harm to health is, it is claimed, small. On the other hand there is another school of thought which claims that the moderate use of alcohol has its proper place in modern civilised life with the continuous stress and strain which it imposes on the individual. At the end of a long and arduous day a small dose of alcohol promotes that relaxation of tension and that sense of wellbeing and exhilaration which, it is claimed, can do no harm to the man and probably helps him to readjust himself to the work that awaits him the next day. Under existing conditions there is, indeed, a considerable measure of justification for both these schools of thought. For certain members of the community, with adequate mental balance to restrain themselves and practise strict limitation on the consumption of alcoholic beverages and with comfortable incomes which make the expenditure on drinks no strain on their financial resources, the deprivation of the desired dose of alcohol after the day's work may well be unjustified. On the other hand for the many millions in this country who, after a day's hard toil, do not earn sufficiently to keep themselves and their families properly fed, clothed and housed, the provision of a temptation to throw away a part of their wages for a transient feeling of contentment can hardly be considered as just either from the point of view of the individual or of the community. When it is remembered that these men are ill equipped, through lack of education and of social training, to place adequate restraint on themselves, it will be recognised that the damage that can be caused to their welfare and that of their dependents may indeed be great.

#### **Certain Generally Accepted Facts regarding Alcohol in relation to Health**

(1) The main action of alcohol is on the nervous system. It depresses the higher centres of the brain. The stimulant action popularly attributed to it is due to a relaxation of tension. With the exception of its action on the respiratory system alcohol never stimulates.

(2) In very small doses it has a sedative effect. It therefore helps to soften the harshness of life and to increase the enjoyment of social intercourse. It produces a temporary sense of well-being which is technically described as euphoria. But even a small dose

of alcohol seems to impair the precision of an act demanding coordination of muscular effort. Jameson and Parkinson in their "Synopsis of Hygiene" state that "Physiological tests on the competence of motor-drivers indicate that driving may be affected by concentrations of alcohol much smaller than those needed to affect the behaviour in ordinary clinical tests." In larger doses intellectual processes are impeded or suspended and even coarse muscular movements are rendered difficult or impossible.

(3) As a food it requires no digestion before it is absorbed into the blood. It is, however, of little value as an ordinary source of energy because of its harmful effects on the higher nervous centres. Unlike other foods it cannot be stored in the body to be drawn upon as required. If taken frequently, the human body is never free from it and certain deleterious changes in the liver and other organs are brought about.

(4) In medical treatment alcohol serves but a limited purpose. In cases of fainting a small dose of alcohol, by weakening the "excessive check on the heart action exercised by the nervous centres, and, on account of its sedative influence on the higher levels of the brain", may exert a temporary beneficial influence in relieving pain and anxiety. But the general medical outlook regarding the use of alcohol in the treatment of disease has considerably changed. We may sum up the position in the following words of the late Lord Moynihan:—

"It is difficult to realise that 50 years ago the use of alcohol was considered necessary in the treatment of disease and advisable for the maintenance of good health..... Today medical science is of one mind that alcohol, while it has its uses, is unnecessary and often harmful in the routine treatment of disease."

(5) As regards its effect on mortality, a comparison between total abstainers and non-abstainers shows that the former are longer lived. In the book already referred to, Jameson and Parkinson state that "Insurance companies have found that the expectation of life is some three and a half years less for non-abstainers than for total abstainers." The extent to which alcohol affects longevity depends on the amount consumed by the individual from day to day. Detailed studies of mortality statistics of American and British life insurance companies seem to suggest that:

"1. Moderate users of alcohol, who touch it only occasionally and then in moderation, are probably as long lived as total abstainers, provided they always maintain moderate habits in all phases of living.

"2. Those who drink moderately, say, an average of two glasses of beer or one glass of whisky per day, have a higher mortality than the average, partly due to a percentage of them eventually exceeding this moderate consumption.

"3. Those who drink occasionally to the point of intoxication, or have a few protracted sprees yearly are distinctly shorter lived than the average."\*

\* The article entitled "Longevity and mortality as affected by the use of alcohol" by Arthur Hunter in the co-operative study, "Alcohol and Man," published by MacMillan and Co., New York (1932), page 342.

## OUR RECOMMENDATIONS

### Certain General Considerations

2. Drinking has, as pointed out by Professor Sigerist in his book "Civilisation and Disease", two main causes. "One is social and economic. Misery, poor living conditions, lack of education and of recreational facilities drive a man into drinking. In Russia in 1913, the annual consumption of vodka amounted to 8.1 liters or more than 2 gallons per person, and the average worker spent over a quarter of his wages on liquor. When conditions of the working population changed after the Revolution the *per capita* consumption of liquor dropped steadily. It was 4.5 liters in 1931, 3.7 in 1935. Whenever people are hard pressed by a sense of misery and oppression, the more will they be inclined to seek oblivion in drink. And the more they take to drinking, the more oppressed and wretched they become.....Another cause of harmful drinking is to be sought in folk customs and group habits. Since alcohol removes inhibitions and makes people talk more freely, it became the custom to drink alcoholic liquors whenever people gathered for social intercourse. This alcoholisme mondain, as the French call it, affects the most highly education classes. It is not so spectacular, but has nevertheless very deleterious results." A campaign for reducing alcoholism in the community must therefore take into account both these factors. A rise in the standard of living accompanied by the provision of educational and recreational facilities on as wide a scale as possible seems to be essential to ensure the success of the campaign. The harmful effects of convivial drinking can be brought home to the people and their cooperation secured for its effective control only through education.

3. The use of alcoholic beverages by human communities dates back to the earliest times and it is not therefore surprising that the ill effects of its immoderate consumption should have been recognised and that strong attempts to restrain and even prohibit its use by various communities should have been made through the compulsive force of religious practice. "It was not, however, until the experimental methods of pharmacology and psychology revealed with exactness the nature of the action of alcohol on man's body and mind in health and disease, under dosage of all sizes and conditions, that what may be called the twentieth century attitude towards the drug developed."\* While even now, in the press and among the public generally, varying views are held regarding alcohol as a problem affecting the individual and the community, there exists a body of scientific knowledge on the subject which, if spread sufficiently widely among the people, will provide in due course the most effective means of securing the largest possible measure of agreement towards the formulation and enforcement of a sound policy for regulating the use of alcohol. From this point of view also we feel that education should be placed in the forefront of our programme of recommendations.

4. The question of dealing with alcoholism raises at once the desirability or otherwise of enforcing prohibition. The latter raises many questions for consideration which fall outside the scope of enquiry of a Committee such as ours, the main interest of which is

\* "Alcohol, its effects on man" by Haven Emerson, M. D. (See the preface).

centred on the health aspect of the alcohol problem. Prohibition, on the other hand, introduces various other considerations such as the extent to which its enforcement is likely to be supported by public opinion, the possibility of certain evils coming into existence in the event of the introduction of this measure being much in advance of public opinion and the administrative aspects of the problem, including questions of finance and of effective preventive work. These matters fall clearly outside the range of our investigations. Nevertheless, from what has been said earlier about the importance, from the standpoint of health, of restricting the consumption of alcohol to the greatest possible degree of moderation, we cannot absolve ourselves of the responsibility to put forward certain proposals directed to serve this purpose. We feel, at the same time, that legislative and administrative measures, however cleverly designed and enforced, cannot achieve the desired result unless the intelligent cooperation of the people can be secured in the enforcement of these measures. From this point of view also education of the people should form an essential part of the campaign against alcoholism.

Although we do not propose to express any definite view either for or against prohibition we shall refer to one aspect of this subject at a later stage in this chapter.

#### **Education regarding the Fundamental Facts in relation to Alcohol**

5. We understand that, in the United States, all but two States (Arizona and Wyoming) have laws requiring that all schools supported partly or wholly from public funds should include, in their curricula for children, courses of instruction dealing with the effects of alcohol and other narcotics on the human system.\* We desire to see such provision made in this country also. In providing such instruction it is in our view essential that all the fundamental facts relating to alcohol should be made available to the school children and that controversial views, which are generally based more on personal predilections than on a dispassionate review of the problem, should be avoided as far as possible. The socio-economic aspects of the problem should not, however, be ignored. A body of scientific facts presented without any reference to their social consequences fail to stir the imagination of most people and particularly of children. We would suggest that proper text-books on the subject should be prepared by some central agency and that they should be translated into all the languages of individual provinces by the respective Provincial Governments. In doing so it should be possible to include material, diagrammatic and narrative, which will give a local colour to the different subjects that are discussed. We strongly believe that such instruction will, when carried out over a period of years, create a new generation of men and women who will help to solve the problem, both in its individual and community aspects, without the handicaps of undue inhibition against, or of established predilection for, alcohol arising probably from the social surroundings in which they are brought up. Such instruction is equally necessary for the older members of the community, although we believe that the results obtained are not likely to be so lasting as in the case of children. The approach towards educating the adult in respect of alcohol will have to be developed on a wide basis and the methods to be adopted

\* "Alcohol, its effects on man," by Haven Emerson, M. D. (See the preface).

will form a part of the general programme of action against alcoholism which will be discussed in the succeeding paragraphs.

### **Certain Other Suggestions for Combating Alcoholism and for Restricting Alcohol Consumption to the Minimum**

6. The alcoholic habit is in this country largely confined to certain sections of the population. The Mohammedans are prohibited its use and certain sections of the Hindus have also similar religious restrictions placed on its consumption. These restrictions are in the main being observed by these sections of the population. There still remain large groups among the Hindus to whom the use of alcohol is not forbidden. This is also the case with some other communities in the country. Among these the consumption of alcohol exists to a greater or lesser extent while, in urban areas, a loosening of the traditional restrictions brought about by modern conditions has introduced the drink habit to a varying extent among all classes of the people. In the villages, on the other hand, the force of custom and the pressure of local public opinion have in the main tended to limit the consumption of alcohol mostly to those who have been traditionally accustomed to it. We would therefore suggest that the problem may be dealt with somewhat differently in the towns and in the countryside.

#### **The Urban Areas**

7. Here, apart from the special features to which we referred in the previous paragraph, another important factor is, in many cases, the presence of varying proportions of industrial workers, who live either interspersed among the general population or in colonies mainly inhabited by persons of their own class. The drink habit is widely prevalent among such workers, some of the reasons being (1) that they are largely drawn from those sections of the community to whom the use of alcohol is not forbidden and that they might therefore have been accustomed to its use in the villages from which they migrated, (2) that these workers live often without their families and are therefore likely to find few opportunities for relaxation after a hard day's work except through the escape from reality that alcohol offers and (3) that they have more money to spend on drink through the larger wages they earn.

8. In referring to the social and economic aspects of the drink problem we have pointed out how unjustifiable it is that many millions in this country should spend a proportion of their wages on drink, although their earnings are quite insufficient to meet such essential needs, in respect of themselves and of those dependent on them, as adequate food, clothing and housing. Industrial workers and other relatively large sections of the population in urban areas belong to this category and measures designed to restrict the use of alcohol by them cannot be commended too strongly for adoption for health and economic considerations.

9. In the first place there should be an attempt to restrict the consumption of alcohol on as wide a scale as possible. The necessary measures will include the strict control of existing liquor shops and the severe restriction or even the prohibition of the opening of new shops, particularly in the areas occupied by the poorer sections of the community including industrial workers. There should be a reduction in the hours of sale of alcohol. The alcoholic content of the beverage sold in such places for public consumption should be



within certain limits to be prescribed by the Provincial Government. The aim should be to make places, where alcoholic beverages are permitted to be sold, decent establishments where a high standard of cleanliness is maintained and suitable alternative refreshments are provided, so that a man can take his family and order food along with drinks. The experience in the West is that, under such conditions, the excessive consumption of alcohol is generally checked.

10. Side by side with such measures there should be provision for the supply of non-alcoholic beverages. Milk bars, tea and coffee shops, if run on cheap lines, can help to divert the craving for intoxicating drinks into less harmful channels. The desire for alcohol at the close of the day is perhaps partly stimulated by the lack of opportunities for other forms of useful activity, including recreation and social intercourse. We believe that, if the proposed post-war educational developments will create facilities for adult education, general and technical, on a wide scale and if increased opportunities for successful careers are provided to ambitious men and women, the incentive for conserving and spending money and energy on lines likely to lead to self-advancement will become sufficiently strong to prove a deterrent to the wasteful pursuit of transitory pleasure to which alcohol opens the way. Side by side with such developments there is abundant room for the promotion of social and recreational facilities. These coupled with the opportunities for educating the grown up population in the fundamental facts relating to alcohol, which the adult education programme will provide, are bound to bear fruit in the course of years by increasing the active cooperation of the people in the campaign against alcoholism.

11. In the meantime the control exercised by Governments over the sale of alcoholic beverages to the people should be as stringent as possible. The Provincial Governments obtain today a substantial part of their revenues from alcohol. We agree with Haven Emerson that "little economic merit can be claimed for a system of taxation which raises any considerable part of the public revenue from the sale of alcohol, unless, as a part of the plan of government, this tax money is used to reduce the extent of facilities for the sale of alcoholic beverages; to promote observance of restrictive laws; to meet the cost of prevention, care and treatment of alcoholism among the considerable number of persons whose health will be injured and whose earning capacity will be reduced by the use of alcohol". It seems important to us that a substantial part of the money so derived should be devoted by Governments in this country to measures designed to prevent the spread of alcoholism and to rehabilitate those whose health and working capacity have been injured by the excessive use of alcohol.

### **Treatment and Rehabilitation of Alcoholics**

12. The treatment of acute and chronic alcoholism is essentially a medical problem and adequate provision should be made for it as a part of the general health programme. The rehabilitation of the chronic alcoholic is, however, a much wider problem. Here, apart from any medical measures that may be adopted, there is the question of re-educating him to a saner outlook on life and his responsibility towards those who are dependent on him. The rescuing of the growing children in the home of such an individual from the degrading effects of brutish behaviour resulting from drunkenness is an

equally important matter. We would suggest that the establishment of houses of detention for those alcoholics who require segregation and treatment, medical and social, should receive serious consideration. Legal sanction for such detention will, no doubt, be required and the question of acquiring the necessary powers should also be considered. The dependents of the person so detained may, in many cases, require support until the individual is set free and his earning capacity is re-established. The provision of such medical aid as may be necessary can also be made a part of the organisation established in the house of detention.

13. In this sphere of activity voluntary effort can render valuable help. The rescuing of the individual back to normality can be helped enormously by properly directed efforts in which social workers and religious leaders should, in our view, take an active part. Indeed, the possibility of organising and maintaining such houses of detention under voluntary auspices, with generous support, financial and technical wherever necessary, from the State may well be considered. If such institutions are maintained under private auspices, the State should ensure that they attain certain definite standards of efficiency which it prescribes.

#### **The Rural Areas**

14. The problem is essentially the same in the rural areas as in the towns. A point of difference, however, is that in the former the alcoholic habit is, in view of the pressure of local public opinion, likely to be confined mostly to those classes which are traditionally accustomed to its use. It should be comparatively easier to pick out chronic alcoholics in a village than in a town. The development of a strong public opinion against drunkenness should also be easier. But the provision of medical and other remedial measures and the mobilisation of voluntary effort to promote activity on the lines indicated in the previous paragraph may not prove as easy in rural areas as in the larger urban centres. While therefore we recognise that the problem of alcoholism in the rural areas is no less important than in towns we would suggest, in the first instance, the inauguration of the campaign against it on the elaborate lines suggested above in a few of the larger cities and towns in each province and its gradual extension to other parts later.

#### **Certain Common Measures for Urban and Rural Areas**

15. We wish, however, to see certain parts of the programme extended simultaneously all over the country. These are a strict control of existing liquor shops towards the maintenance of better standards of cleanliness, a reduction of the hours of sale and the regulation of the alcoholic content of the beverage sold to the public for consumption. The opening of new shops should be severely restricted and even prohibited in close proximity to the areas where industrial and other workers live.

16. The consumption of alcohol, during working hours, by persons engaged in certain occupations is dangerous to themselves and to others. For instance, pilots in charge of aeroplanes and motor drivers should be forbidden alcohol during working hours. It should be an offence punishable under the law for such persons to be found in a drunken state when engaged in their respective occupations. We have given these only as typical instances and there are many others in which the use of alcohol should be equally forbidden in the interests of the community.

17. There is abundant evidence to show that the efficiency and output of the industrial worker are lowered by alcohol and that the accident rate is raised.\* The enforcement of total abstinence during working hours appears therefore to be of advantage from the point of industry and of workers alike.

#### **Recent Prohibition Experiments in certain Provinces**

18. A few years ago certain Provincial Governments introduced prohibition in limited areas within their territories and the scheme worked for varying periods in the different provinces. In 1940 the Central Advisory Board of Health, after reviewing the reports which it received from the provinces concerned, came to the conclusion that the material available would not justify judgment being passed either in favour of or against prohibition. The desirability of assessing the effect of prohibition on the health of the inhabitants of the areas concerned was, however, stressed. As far as we are aware prohibition has been abolished in all the provinces. If the scheme is revived at a later date we would strongly recommend that the following suggestions should be adopted.

19. The effects of prohibition on the health of the people may be twofold, (1) the direct effect on habitual drinkers as the result of alcohol being withheld from them and (2) the indirect effect on the health of their dependents through more money being made available for food, clothing and other necessities. We would, therefore, suggest that, before prohibition is introduced in an area, a preliminary survey should be carried out for the purpose of assessing the health and economic condition of the habitual drinkers and their dependents. Such a survey will obviously have to be limited to certain selected towns and villages in the area concerned. These should be taken on the basis of such selection as will secure for them collectively a representative character in respect of the area under prohibition. This preliminary survey should be followed by annual surveys which cover the same individuals and their dependents. Information collected on these lines for a few years should make it possible to draw reasonably satisfactory conclusions regarding prohibition in relation to the health and general welfare of the people.

20. It is desirable that such surveys should be conducted on a fairly uniform basis in the different provinces so that comparable data may be obtained. We suggest that the Central Health Department should, in consultation with the authorities in the provinces in which prohibition was tried, draw up detailed instructions regarding such surveys and make them available to Provincial Governments.

#### **Other Narcotics**

21. While we have confined ourselves to alcohol in this chapter there are other narcotics the consumption of which also produces harmful effects. Examples are, opium, charas, ganja and others. As far as we are aware there is no reason why their use should not be prohibited except for medicinal purposes. We recognise that there are varying proportions of the population in the different provinces who are accustomed to their use for long periods. We would suggest a gradual reduction in the quantities of these drugs which are made available to the people and their complete elimination from public consumption within a period of about ten to fifteen years.

\* See pages 354-361 of "Alcohol and Human Life" by C. C. Weeks (Second edition) 1938, published by H. K. Lewis and Co. Ltd., London.

## CHAPTER XXX

### THE INSTITUTION OF A MEDICAL LIBRARY SERVICE ADEQUATE FOR THE REQUIREMENTS OF INDIA

1. It is evident that one of the prime needs of an intellectual community is an effective library service, and this is more especially the case where a highly technical subject such as medical research is concerned. India is at a great distance from the other centres of scientific thought, and she must inevitably draw her knowledge of advances and discoveries from books and journals published in other countries. She must, in that respect, be largely self-contained and her need for a full and well-selected Central Library is even greater than that of Europe and America, where facilities for the dissemination of knowledge are more highly developed. Such a central library should be fully adequate both for reference and for the purposes of research. It should be linked with a chain of smaller regional libraries in the more important centres of medical research and education in the provinces, by a flexible and extensive service of exchanges.

2. We are told that there is at present no medical library in India with more than 11,000 volumes, apart from bound numbers of periodicals, while the library in the office of the Director General, Indian Medical Service, contains only 20,000 volumes. India has not the funds to enable her at present to institute a library comparable with the more important medical libraries of the world, such as Washington with its 420,000 volumes, Leningrad with 600,000, Paris with 500,000 or even with that of the Royal Society of Medicine in London with 180,000 volumes. It seems to us, however, to be not unreasonable that we should recommend the establishment in India of a Central Library, providing, in the first instance, for the housing of 60,000 to 100,000 volumes.

3. A medical library of about the size that we have in mind exists on the Pacific Coast of America—the Lane Medical Library at Stanford University housing, in 1928, a representative collection of 65,000 volumes along with a large collection of pamphlets and reprints, and subscriptions to 460 journals from all parts of the world. Owing to the geographical situation of California and its distance from the more important centres in the Eastern States this library has to be relatively self-contained. The problem was in many ways parallel to that which India will have to face and a study of the manner in which it was dealt with should prove profitable to us. The special building which houses the library cost 160,000 dollars (Rs. 4½ lakhs) with reading-room space for 140 readers and stacks to hold 75,000 volumes with ample provision for expansion. The budget for the year 1927-28 was 17,150 dollars (half a lakh) exclusive of heating and lighting. Of that sum 8,792 dollars were allotted to salaries and 8,357 dollars to books, periodicals and binding.

4. We feel that the following quotation from Miss Janet Doe's recent "Handbook of Medical Library Practice" (1948) sums up so well our own conception of what is required from a library of this type that we reproduce it from the original text.

"A well-rounded medical library must consist in major part of periodical material, including journals and serials

of many types. It is a reversal of the proportion obtaining in a general library to find these forming the backbone of the medical collection. They contain the first recorded reports of scientific discoveries and additional ever mounting comments, criticisms and supplements on these reports. After periodical literature, monographs and text-books on special subjects are a necessary part of the library. Reference books of many varieties are needed. Some of these are the same as those in general use but the majority vary widely from this list. Pertinent medical information, whether it be published in government documents, society or hospital reports, health surveys, vital statistics, medical school catalogues, congresses or elsewhere, must be discovered and placed in the library. All this literature must cover material on the basic sciences, on general medicine and on the specific fields in medicine in the proportion needed by the library clientele. It must represent not only publications in the English language but outstanding contributions from all over the world, either in original or abstract form. Moreover, background material, as histories, biographies and autobiographies, rare books, incunabula, economic studies and ethical discussions are desirable in a well equipped library. Such a collection should also, if possible, include works of cultural value for medical readers and books with a medical background written by physicians and non-medical writers.

"The intensive research usually in progress at a medical school presupposes a library stocked with data or work done on medicine and its accessory sciences in all countries and all ages. This means it must contain or have access to a large collection of periodicals, monographs, atlases, textbooks, encyclopedias and other literature to supplement the professor's private library and the student's textbooks. In addition, the library must be able to supply medical and vital statistics, book publication information, biographical data about physicians and scientists and other reference material upon request. And finally it may be called upon to provide writings on the history of medicine and cultural medical literature. This is an ideal. If it cannot be attained in practice, it must be approximated by purchases emphasizing the general and special interests of faculty members."

Obviously the collection and supervision of such a library must be the work of a highly trained librarian, specializing in medical literature. Miss Doe offers valuable information as to the availability of such librarians in the U. S. A.

"To staff these libraries, workers have been enticed or commandeered from general and special libraries, from library schools, from the clerical staff of hospitals or medical schools and from doctors' offices. Seldom, indeed, has it happened that a medical library could secure a librarian with both professional library training and education or experience in the medical sciences.

Library schools have been unable to give the requisite specialized training—though two or three now offer brief extension courses; it is only within the past few years that internships in medical libraries have become possible, and they are still few. An exceptionally definite need exists, therefore, for a means of liaison between the medical library and the sources from which it must draw its librarian."

5. We are fully persuaded that, in order to put the proposed service on a sure foundation, it will be necessary for an exploratory survey of the facilities existing in the United Kingdom, the United States and elsewhere to be undertaken by one or two officers (of whom at least one should be an Indian) deputed for the purpose.

A suitable programme for such a deputation is suggested below:—

(1) A study of medical libraries in the U.S.A., such as those at New York, Boston, Philadelphia, Baltimore, Washington and the Lane Library at Stanford University. Contacts, *inter alia*, with the Rockefeller Foundation, the Surgeon General's Library, the Medical Library Association and publishers of medical literature.

(2) A study of the medical libraries in the U.K. especially those of the Royal Society of Medicine, the Royal College of Surgeons and the Radcliffe Library at Oxford. Also the National Central Library regarding exchange facilities between libraries.

(3) Investigation of the scope of translation, abstracting, photostat and micro-film services from United States of America and United Kingdom.

(4) Obtaining rough estimates from various sources of estimates of cost in respect of buildings, staff and other facilities which should be provided.

6. We suggest that there should be, in London, a correspondent of the library, who will watch its interests in the West and act as the channel both of information and of supply in matters concerning the library service.

7. If an experienced librarian proves to be immediately available, we suggest that he should be engaged on a preliminary two or three years' contract to work in the first instance in the Directorate of Health together with the Indian officer who has made the survey, in establishing a catalogue of books and periodicals to form the nucleus of the Central Library, and initiating courses of training for junior members of the library staff and also in consulting with the architects engaged on plans for the library.

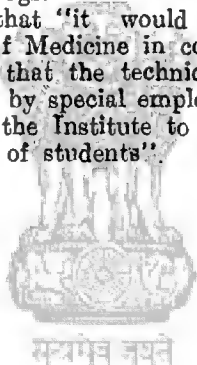
8. The Central Library we envisage is one chiefly devoted to research and should be established in association with the All-India Medical Institute we have recommended. When similar Medical Institutes are established elsewhere they will have to be provided with their own libraries. A case can be made out for an entirely separate Library in the Directorate of the future civil Health Service, devoted to general reference and to the problems of administration. We prefer, however, to leave that question, together with proposals for the establishment of regional libraries, to the consideration of the Governments concerned after the survey which we have suggested has been completed, when fuller and more exact information will be available.

9. In a recent number (February 1945) of the Bulletin of the History of Medicine, Professor Henry E. Sigerist drew attention to the need for an Institute of the History of Medicine in India, and made the following suggestions which are germane to the present subject and worthy of consideration when planning is to be done.

"The staff will require tools for research, that is, collections and among them primarily a collection of books. The library of the Institute will include the basic medico-historical literature—books and journals—medical texts in the best editions and translations available, and as many reference books as possible. It should also include a number of non-medical books, such as basic books on political, social and economic history, the history of philosophy, religion and other disciplines, books that are constantly needed for general orientation.

"The Institute will in addition collect other documents pertaining to the medical history of India, manuscripts, photographs, portraits, objects such as instruments, etc., and it may consider the creation of a museum of indigenous drugs."

He suggested further that "it would be advisable to build the Institute of the History of Medicine in connection with, or as an annex to the Library, so that the technical administration of the Institute could be handled by special employees of the Library. This would permit the staff of the Institute to devote all their efforts to research and the teaching of students".



## CHAPTER XXXI

### LEGISLATION

1. We do not propose to make here any detailed survey of the health legislation which is likely to be required for the execution of the programme we have set forth in the preceding chapters of this volume of the report, or to make specific recommendations regarding the manner in which the existing laws should be amended or added to. We feel that we are not competent to undertake either of these tasks satisfactorily. As regards the survey we believe that, even if it be carried out by a more competent agency than ourselves, the full range of legal enactments which may be required is not likely to be covered. Legislation and administration constitute parallel lines of state activity, which continually act and react on each other, with the result that the implementation of our programme is bound to produce, as it proceeds, the need for legal powers in various directions, which can hardly be anticipated at this stage. The manner in which changes in the existing law should be made to suit the requirements of our health scheme is a matter for consideration by Governments in consultation with their legal advisers. While recognising these facts we consider it desirable to give in one place a brief review of the more important matters on which we have recommended legislation in different parts of our report. The present chapter attempts to carry out this purpose.

2. Our proposals for legislation fall mainly under four heads:—

(1) those which are intended to assist in the formulation and execution of a national health policy based on the largest possible agreement between the Central and Provincial Governments and to promote the co-ordination of central and provincial health activities;

(2) those which are designed to improve health administration in the provinces, particularly the standard of such administration in local areas;

(3) those which are required for conferring special powers on health authorities to enable them to carry out their duties more effectively than they are able to do at present and

(4) those which are intended to give statutory sanction to certain proposals of ours, *e.g.*, the All-India Medical Institute, certain aspects of which involve departures from existing administrative procedure.

We shall now refer briefly to the legislation likely to be necessary under each of these heads without going into a detailed consideration of the reasons for the establishment of the institutions or approval of administrative policy for which legislative sanction is to be sought. These matters have been discussed in the relevant places. We shall refer only to the more important matters requiring sanction by the legislature.

#### **The Formation and Execution of a National Health Policy and the Co-ordination of Central and Provincial Health Activities**

3. We have recognised the retention, as far as possible, of the large measure of autonomy which the provinces have enjoyed for some-time past, and have suggested that the Centre should promote the development and co-ordination of provincial health activities mainly



by the provision of machinery for mutual consultation in the formulation of the national health policy, by a system of grants-in-aid from Central Funds to the provinces and by the offer of technical advice to provincial health authorities. At the same time, we feel that, in certain exceptional cases, it may become necessary for the Centre to intervene in the affairs of a province in the interests of the country as a whole, and have therefore suggested that the Centre should be armed with the necessary legal powers. Our proposals to serve these purposes include:—

(a) the establishment of a statutory Central Board of Health with the Central Minister of Health as the Chairman and Provincial Ministers of Health as members.

The Board will provide the forum for the discussion and formulation of a health policy based on the largest measure of agreement between the Centre and the Provinces. Through the opportunities that it will provide for mutual consultation, the Board will assist in the carrying out of that policy with the least possible friction between the different Governments. The Board will also be responsible for recommending, to the Central Government, proposals for the distribution of grants-in-aid to the provinces.

(b) a modification of the existing relationship between the Centre and the Provinces to the extent of enabling the former to intervene, without delay and effectively, in provincial health administration in circumstances in which dereliction of duty by a Provincial Government jeopardises the health not only of those under its charge but also of those living in adjoining areas outside its jurisdiction.

Normally the Centre is expected to act, on such occasions, only after consulting the Central Board of Health. Where immediate action is required, the Central Government should report to the Board the measures it has taken with the least possible delay.

#### **Improvement of Provincial Health Administration**

4. Here the measures necessary relate mainly to the sphere of health administration in local areas and statutory sanction will be required for:—

(a) the creation of district health boards on the lines indicated by us;

(b) the provision of power to the provincial Minister of Health to enforce compliance by the Board with the policy laid down by him;

(c) in the areas under our scheme (i) the provincialisation of all classes of health workers and (ii) the conferment upon the Governments of other provinces, of powers similar to those that exist in the province of Madras whereby the head of the Public Health Department can recommend specific action by local health authorities in particular directions for the improvement of the public health and can enforce their execution, subject to the concurrence of the Provincial Government, and

(d) in the areas outside our scheme, the provincialisation of those classes of health personnel which are now recruited and maintained

on a provincial basis in Madras and the provision of the powers referred to in (c) (ii) above.

**Special Legal Provision for enabling Health Authorities to carry out their duties effectively**

5. We have discussed, in the different sections of our report, the legal provisions which are required, in our view, to supplement the existing powers of health authorities in order to improve health administration in its different branches. We shall refer here only to two matters, namely, the control of infectious disease and an improvement of the purity and quality of the community's food supply. In doing so our main purpose is to emphasise the part the Central Government can play in both these fields of health administration to supplement what is now being done by Provincial Governments.

(a) *Control of infectious diseases.*—In view of the urgent need for controlling the incidence of malaria, which is by far the most important among the infectious diseases prevalent in India from the point of view of morbidity and mortality, we consider it essential that adequate powers for the enforcement of antimosquito measures should be conferred on local health authorities on the lines indicated by us. Another important provision is that primary vaccination and revaccination against small-pox should be made compulsory in areas where these provisions do not exist at present.

In the chapter on quarantine we recommended that, in order to prevent the inter-provincial spread of infectious disease, the Central Government should be given certain legal powers based on existing practice in the United States. We described briefly the powers which the Federal Government in that country possesses for this purpose and suggested that any modification of the existing law in India, which may be required to enable the Centre to perform such functions, should be brought about without delay.

We also recommended the drawing up, by the Central Health Board in consultation with their health advisers at the Centre and in the Provinces, of a memorandum of instructions to be followed by the Central and Provincial Health Departments in order to promote joint action, on an effective basis, when inter-provincial spread of infectious diseases threatens or actually takes place. These instructions can be given legal sanction if they are issued as statutory rules by the respective Governments under the powers they already possess or which they propose to acquire under a consolidated Public Health Act, the enactment of which we have recommended in Chapter XVII of this volume of the report.

We consider that action on the lines indicated above is essential for strengthening the existing law for the control of infectious diseases.

(b) *Control of the purity and quality of the community's food supply.*—Besides the recommendations we have already made under these heads in the relevant places, which relate mainly to provincial action, we may put forward here a suggestion for enabling the Central Government to play an important part in this field in so far as inter-provincial trade in food is concerned. This recommendation is also based on existing practice in the United States. In that

country, while the fixing of standards of purity and their enforcement in respect of all articles produced and consumed within a State are the responsibilities of the Government of that State, any article which seeks to enter the field of inter-State commerce must conform to standards prescribed and enforced by the Federal Government. The latter possesses powers of inspection, within the State, of the premises and of the processes of manufacture of the article concerned, as well as of taking samples there and at all the stages of storage, transport and distribution to the public. In India many articles of food enter the field of inter-provincial commerce. Most of the dairy products (*e.g.*, ghee, butter, khoa) come within this category as well as edible oils and tea and coffee. The enforcement of the food adulteration law is a provincial responsibility and, although the Central Advisory Board of Health recommended the adoption of common standards by all provinces, it is understood that such uniformity has not been attained in respect of all articles of food. Moreover, the enforcement of the food adulteration law in the provinces leaves much to be desired. In these circumstances, if the Centre can enter the field and assist in the enforcement of the required standards, an advance will undoubtedly be made in the control of food adulteration.

As regards an improvement of the quality of the community's food supply, we drew attention in the chapter dealing with nutrition to the Agricultural Produce Grading and Marking Act which is intended to facilitate such improvement and pointed out that a number of agricultural food products is already under the operation of this Act. We also recommended there that the principles of this Act should be made applicable to articles of food other than agricultural. This is an Act of the Central Legislature and we suggest that the Central Government should give early consideration to this recommendation.

#### **Legislation in connection with certain other proposals of ours**

6. The more important of these proposals are those relating to:—
  - (a) the All-India Medical Institute;
  - (b) the establishment and maintenance of institutions in the provinces for providing, on an all-India basis, postgraduate training facilities of a high order and
  - (c) the Central and Provincial Water and Drainage Boards.

In regard to the All-India Medical Institute we have recommended that the recruitment of its staff should be through its Medical Faculty consisting of its professors and not through the channel of the Federal Public Services Commission. This departure from the normal procedure for recruitment and certain other matters in connection with this Institute would seem to require statutory sanction.

Similarly, our proposals for developing postgraduate training facilities to serve the needs of all provinces involve questions of administrative control and apportionment of cost between the Centre and the Provinces as well as the establishment of an all-India body, the Central Committee for Postgraduate Medical Education, which will have technical control over such institutions. Statutory regulation of these matters will probably provide a more satisfactory and stable basis for central and provincial co-operation in this field than administrative arrangements entered into by the Central Government with individual Provincial Governments.

The Central Drainage and Water Board will make recommendations to the Central Government regarding inter-provincial questions of water conservation, drainage and river pollution and we have suggested that the Central Government should be granted power, in cases of emergency, to give an interim decision, which will be binding on the provinces concerned, while the final decision should lie with the Federal Court or an Arbitration Board as may be provided for. Statutory sanction will obviously be required for bringing into existence such a Water and Drainage Board and for regulating the procedure to be adopted in connection with its recommendations, involving as this may often do, matters of vital importance to more than one province in the country. Further, the Board, if it is to carry out such investigations as may be necessary for making its recommendations to the Central Government, will require in many cases access to records and the evidence of individuals, which it should be in a position to secure as a legal right. From this point of view also statutory sanction for the establishment of the Board and its functioning seems essential.

The reasons advanced above for legislation to regulate the establishment and functioning of the Central Water and Drainage Board apply also to the Provincial Boards. Questions relating to water conservation and river pollution may involve the interests of individuals and organisations and statutory provision for the settlement, on an equitable basis, of disputes regarding such interests is therefore essential. Here also the Provincial Government may be empowered to give an interim decision which will be binding on the parties concerned, while the final decision may be left to the Provincial High Court or an Arbitration Board as may be provided for.

#### **Consolidated Public Health Acts, Central and Provincial**

7. The enactment of consolidated Public Health Acts by the Central and Provincial legislatures is considered necessary. Such Acts can serve at least three purposes, namely, (1) to bring together existing legal provisions relating to health, which are scattered over various enactments, (2) to modify those sections of the law which require change in the interests of promoting efficient administration and (3) to incorporate the new provisions which will be necessary for the development of the health programme we have recommended. At the Centre provisions relating to health are found in about 40 different Acts while, in the provinces also, a varying number of legal enactments contain such provisions. The need for the modification of existing law may be illustrated by a reference to leprosy. In certain provincial Local Self-government Acts the provisions for dealing with this disease are the same as those provided for such acute and rapidly spreading infections as cholera, small-pox and plague. Leprosy is, on the other hand, an endemic disease and spreads slowly from person to person as the result of opportunities for fairly prolonged and close contact. In the case of the common infectious diseases the patient requires segregation and treatment for a limited period only and, speaking generally, he becomes non-infectious as soon as he is cured. In leprosy, on the other hand, the period of infectivity is prolonged and uncertain and the patient requires segregation and treatment for an extended period, which may run into months or years. Administrative procedure for dealing with leprosy and with the other diseases of a more acute and rapidly developing type will

8. Such legislation at the Centre and in the Provinces may take some time to materialise. In the meantime it is recommended that the Central Government should undertake to bring together in a single publication all the existing laws relating to health, both Central and Provincial.



## CHAPTER XXXII

### THE FINANCIAL IMPLICATIONS OF OUR PROGRAMME

#### Introduction

1. Our proposals for the development of health services in the country, on lines which follow modern trends, consist of a long-term plan, which is intended to provide health protection of a comprehensive nature to the whole population, and of a shorter plan to be completed in a period of ten years which, while following the broad outlines of the larger scheme, is more restricted in scope, both in respect of the health services to be rendered and of the population to be served. In defining the objectives to be reached on the completion of the long-term programme, we have been mainly guided by the consideration that the health services provided for the people should be comprehensive in their scope and that they should be based on the latest developments that the science and art of medicine have to offer. On the other hand, in drawing up our proposals for the short-term programme we have given careful consideration to the instructions of the Government of India on the financial aspect of planning, which were embodied in the terms of reference defining the scope and nature of the enquiry entrusted to us. The Government of India said that it was desirable "to plan boldly, avoiding on the one hand extravagant programmes which are obviously incapable of fulfilment and on the other halting and inadequate schemes which could have no effect on general health standards and which would bring little return for the expenditure involved". It has not been an easy task to harmonise the requirements of a scheme sufficiently broad-based to ensure the realisation of a progressive improvement in the public health with the need to bring its cost within such limits as are likely to be considered reasonable from the point of view of the country's financial capacity. We decided that our guiding principle should be that the short-term plan we advocate must be such as would produce, through its implementation, an appreciable improvement in the health of the people within the period of completion of the plan. This is a matter of even greater importance than questions of cost. We were strengthened in this view by two considerations. One is that planning would defeat its purpose if no satisfactory results could be demonstrated. We felt that the consequences of such failure might even be a setback, for many years to come, in the development of health administration in the country.

2. The other consideration is that, if the rates of expenditure incurred by Provincial Governments on their medical and public health departments were to be taken even as an approximate guide to determine the financial limits of our proposals, any attempt to build a satisfactory scheme of health services for the people would be foredoomed. In 1939-40 the per capita expenditure on these two departments together was Re. 0-1-7 in Bihar, Re. 0-1-9 in the United Provinces, Re. 0-2-1 in the Central Provinces, Re. 0-2-3 in Orissa and Re. 0-2-7 in Bengal. The highest figure for such expenditure was Re. 0-5-9 in the province of Bombay. In order to ascertain what an improved health service is likely to cost it may not be out of place to examine the corresponding expenditure for certain other countries, where the provision for affording health protection

to the people exists on a much larger scale than in India. In Great Britain, the per capita expenditure on medical and public health activities was, in 1934-35, about Rs. 54-8-11 and in the United States the corresponding figure for 1938 was Rs. 51-6-0. We recognise that the expenditure incurred by a country on its health services must necessarily depend on its national income and that India compares, in this respect, very unfavourably with the two countries mentioned above. Estimates of national income are likely to show a varying margin of error, however carefully they are made. Nevertheless, we may take for the purpose of comparison, certain estimates for these three countries from sources to which we may reasonably attach value. The figures are given below and the sources from which they are derived are also indicated:—

Country	Income per capita			Source of information
	Rs.	A.	P.	
British India . . . . .	62	3	3	The National income of British India, 1931-32 by Dr. V. K. R. V. Rao.
Great Britain . . . . .	1,049	6	5	Journal of the Royal Statistical Society, Vol. 103, 1940, page 517.
United States . . . . .	1,371	7	3	Monthly Labour Review Vol. 53, 1941, page 114

The per capita income of the United States is about 22 times that of India and that of Great Britain about 17 times. Even after making due allowance for the much higher national incomes in those countries, India should spend annually about Rs. 3-8-0 per head of the population if her expenditure on health services were to bear the same relation to national income as the amount spent in Great Britain in 1934-35 on health measures bore to her own national income. On the basis of a similar comparison with the United States India's per capita expenditure on health should be Rs. 2-5-0. From our survey of modern trends in the organisation of health services in Chapter II of this volume, it will be seen that the authorities in those countries are dissatisfied with the provision for the health protection of their people which the figures quoted above represent, and that expenditure on a generous scale to augment the existing services is under active consideration. In these circumstances we felt that, if India desired to develop a modern health organisation, a scale of expenditure much in advance of what the provinces have been incurring, was inevitable. We therefore decided to plan our short term programme undeterred by the cramping limitations of existing provincial expenditure and with our main consideration directed to the development of a plan which would ensure, through its execution, a demonstrable improvement of the public health. We hope to show later that the scheme we have put forward is, even from the financial point of view, in no way extravagant or unreasonable. Though the expenditure involved will undoubtedly be many times that now incurred by Governments in the country, the responsibility which rests on the authorities concerned for finding the necessary funds is, in our view, inescapable, if a raising of the general level of health and prosperity among the people is to be secured and maintained. We cannot emphasise too strongly the fact that one of the most effective means of increasing the national productive capacity is improvement of the public health.

### The Estimates of Cost

3. Having formulated our proposals we examined in some detail their financial implications. The detailed estimates we have prepared are given as appendices 54 and 55 in volume III of this report. These estimates are necessarily of a tentative character owing to a number of reasons, some of which are indicated here. In view of the conditions arising out of the war and its aftermath, building costs can hardly be predicted with any degree of precision for the period during which this programme will be implemented. Further, the cost of construction varies in different parts of the country. Moreover, as we shall point out later, the cost of construction under the supervision of the Public Works Departments of Governments seems, in many cases, to be definitely higher than the cost of construction under other auspices and, if steps can be taken to reduce the former to any appreciable extent, we have no doubt that there will be a considerable decrease in the total expenditure we have shown in our estimates. For reasons which we have stated in the chapter describing our short-term programme, the rates of pay we have assigned to the different classes of health workers are, in some cases, based on existing scales and, in others, on scales we have arbitrarily proposed. In view of the importance and complexity of the problem of fixing reasonable and adequate scales of pay for all public services, we have suggested the investigation of this matter by an *ad hoc* committee. Any decisions that Governments may take on the advice of this committee will, if there be wide departures from the scales of pay suggested by us, materially affect the financial implications of our proposals because, as regards the recurring cost, expenditure on the pay of the health staff constitutes by far the largest proportion of the total.

4. We give below, in tabular form, the main items of our estimates of cost separately for the first five years and the second five years of the short-term programme.

#### Approximate estimates of cost in respect of the proposals of the Health Survey and Development Committee for British India

##### Non-Recurring Expenditure

	First five years Rs.	Second five years Rs.	First ten years Rs.
1. Personal health services including the directional organisations associated with the Ministries of Health at the Centre and in the Provinces .	80,88,00,000	118,64,00,000	199,52,00,000
2. Professional Education .	22,45,00,000	19,86,00,000	42,31,00,000
3. Expenditure on other items . . . . .	50,42,00,000	50,20,00,000	100,62,00,000
	<hr/> 153,75,00,000	<hr/> 188,70,00,000	<hr/> 342,45,00,000
4. Centre . . . . .	9,22,00,000	11,32,00,000	20,54,00,000
5. British India as a whole .	<hr/> 162,97,00,000	<hr/> 200,02,00,000	<hr/> 362,99,00,000

##### Recurring Expenditure

1. Personal health services including the directional organisations associated with the Ministries of Health at the Centre and in the Provinces .	116,10,00,000	250,02,00,000	366,12,00,000
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*Recurring Expenditure—continued.*

	First five years Rs.	Second five years Rs.	First ten years Rs.
2. Professional Education	32,00,00,000	35,24,00,000	67,24,00,000
3. Expenditure on other items	4,54,00,000	12,32,00,000	16,86,00,000
4. Leave Reserve	7,83,00,000	15,08,00,000	22,91,00,000
	160,47,00,000	312,68,00,000	473,13,00,000
5. Centre	9,63,00,000	18,78,00,000	28,39,00,000
6. British India as a whole	170,10,00,000	331,42,00,000	501,52,00,000
Payment towards amortisation of non-recurring expenditure	25,78,00,000	74,54,00,000	100,30,00,000
Total recurring expenditure	195,86,00,000	405,96,00,000	601,82,00,000
Average annual expenditure	39,17,00,000	81,19,00,000	60,18,00,000
Average estimated population of British India	315 millions Rs. A. P.	337.5 millions Rs. A. P.	328.25 millions Rs. A. P.
Annual per capita expenditure	1 4 0	2 7 0	1 14 0

5. Before we examine the above figures we wish to make certain general remarks regarding these estimates of expenditure. We consider that the figures give an approximate estimate of the cost that our proposals will involve, although it has not been possible, for certain reasons, to include every item of expenditure likely to be incurred under our scheme. For instance, in regard to the organisation of school health services, we have suggested that two teachers from every primary school in the areas in which these services will be introduced, should be trained to carry out certain remedial and preventive duties under the supervision of the school medical officer and that each of these teachers should be given a monthly allowance of Rs. 10. In the absence of information regarding the number of teachers for whom provision will have to be made, we have not included this item of expenditure in our estimate. On the other hand, some saving in the estimated cost of these proposals is likely to be secured if neighbouring provinces can co-operate in the joint development of certain types of institutions and in the establishment of facilities for the carrying out of various purposes under our scheme. The endemic and epidemic diseases prevalent in fairly wide stretches of contiguous territory in neighbouring provinces are likely to be the same and room therefore exists for the creation of common facilities for combating such diseases. For instance, certain institutions like leprosy hospitals and homes for incurables can be established to serve more than one province. The manufacture of the biological products required for treatment and prophylactic purposes can be undertaken jointly. Again, in the provision of training facilities for various types of health personnel, there may be room for co-operative effort. In regard to the establishment of such organisations as drainage and water boards, it may be advantageous for neighbouring provinces to establish a common body instead of maintaining separate boards. With one or more rivers passing through the territories of both, questions relating to the conservation of water and river pollution are dealt with more satisfactorily through co-operative action than by separate

effort. We anticipate, therefore, that, in the development of our proposals, there is likely to be the promotion of joint activity on a wide scale among neighbouring provinces and that such activity will help to reduce, to some extent, the cost indicated in the estimates given above. In the circumstances we believe that the figures may be taken as a reasonably correct over-all estimate of the expenditure likely to result from the execution of our scheme during the first ten years of the programme.

6. Our estimates do not give the expenditure that individual provinces are likely to have to incur as the result of the implementation of our proposals. They are statements of probable expenditure for all the eleven Governors' Provinces. The cost to be incurred by the Central Government in respect of Centrally Administered Areas has not been calculated in the detailed manner in which we estimated provincial expenditure. The total population of these areas at the 1941 census was 1.6 millions as against 294.2 millions for the 11 Governors' provinces. Conditions vary considerably in the Centrally Administered Areas, *e.g.*, Delhi Province and Baluchistan, so that the formulation of a common plan appears to be difficult. We consider, however, that the suggestions made in respect of the Governors' Provinces can, with suitable modifications, be utilised by the local administrations under the Central Government for making plans for their respective territories. As regards the Delhi Province, we have suggested that the Central Government should demonstrate in this area the implementation of our proposals as well as of the proposals of other post-war planning Committees, in order to promote a many-sided attack on the problems of community life. We have suggested for this province a scheme which provides a larger health staff than that proposed for the other provinces.

7. We have also recommended that the Central Government should be responsible for the establishment and maintenance of an All-India Medical Institute which will provide, when it is fully developed, teaching facilities of a high order, undergraduate and post-graduate in all branches of professional education in the field of health, and will also make provision for the training of research workers. A tentative estimate of the cost of the Institute places the non-recurring expenditure at about Rs. 2 crores and the recurring charges at about Rs. 40 lakhs per year.

8. Taking into consideration the difference in the population between the Centrally Administered Areas as a whole and that of the eleven provinces it is considered that, on a rough estimate, the cost in respect of all health developments in the areas for which the Centre is directly responsible and the expenditure on the proposed All-India Medical Institute may together be somewhere between 5 and 7 per cent. of the total cost for the provinces, recurring or non-recurring. We have therefore taken 6 per cent. as the basis of our calculation for Central expenditure.

9. We have pointed out, in more than one place in this report, the need for the Central Government to promote health development in the provinces by grants-in-aid and through the provision of technical advice to provincial health authorities. The additional financial burden which the Centre will have to bear if these suggestions of ours are accepted will, we anticipate, be settled by

mutual consultation between the Centre and the Provinces. Whatever this additional burden may prove to be, it is now incorporated as part of our estimates for provincial expenditure.

10. We have given the total anticipated expenditure only under certain broad heads, namely, personal health services, professional education and a group comprising other items of expenditure. Non-recurring and recurring costs have been shown separately. It seems to us most likely that large scale expenditure on capital works will be met by Governments from loans and not from current revenues, especially as the financing of the recurring cost of a scheme such as ours and of those of other post-war reconstruction committees will place an extremely heavy strain on the annual budgets of Governments. On the assumption that non-recurring expenditure will be met from loans, we have provided for their amortisation in a period of 80 years at  $3\frac{1}{2}$  per cent. interest, which we were advised to take as a reasonable basis for calculation. We have assumed that the non-recurring cost to be incurred in the two five-year periods of the short-term programme will be spent in equal amounts each year. The anticipated annual expenditure shown above includes amortisation charges also. The probable cost of our proposals therefore makes provision for the yearly recurring expenditure as well as for that which will be incurred, during the first ten years of the programme, in the repayment of the loans, which are to meet the non-recurring expenditure to be undertaken during that period.

11. For calculating the per capita cost an estimate of the probable growth of population in the country during the period likely to be covered by the short-term programme is necessary. The required data for making such an estimate are at present lacking, and any estimates which are put forward must mainly be conjectural. The enumerated population of British India at the 1941 census was about 295 millions and, as the war has ended and the implementation of our proposals may therefore be expected to start without delay, we have assumed that the average population of British India during the first and second five-year periods of our programme will be 315 millions and 337.5 millions respectively. On the basis of these populations, the per capita costs are:—

First five years			Second five years			First ten years		
Rs.	A.	P.	Rs.	A.	P.	Rs.	A.	P.
1	4	0	2	7	0	1	14	0

It may perhaps be of advantage to indicate what the recurring cost is likely to be during the first and tenth years of the programme. These are Rs. 1-3-0 and Rs. 2-13-0 per head of the respective populations, which have been estimated as 300 and 345 millions.

12. We have shown that, even after making allowance for the low national income of our country as compared with those of Great Britain and the United States, the rate of expenditure on medical and public health services in India should be about Rs. 3-3-0 and Rs. 2-5-4 per head of the population respectively. Our proposals involve, during the first ten years of their execution, an anticipated expenditure of Rs. 1-18-6 per head of the population. We therefore claim that the programme of health development we have put forward cannot be considered extravagant from the financial point of view. When it is remembered that, in Great Britain and the United States, a further rise in public expenditure on health services has been considered essential in the interests of the people, we hold that there is

still greater justification for considering that the demands which our scheme will make on the public purse are in no way unreasonable.

### The Financing of the Health Programme

13. We realise, at the same time, that even the proposed per capita annual expenditure of about Rs. 1-4-0 during the first five years of the programme will require that Provincial Governments should make provision, for spending on health measures, amounts many times in excess of what they are budgetting now. The latest available figures for the combined expenditure on provincial medical and public health departments relate to 1944-45 and they are given below.

#### Combined expenditure on medical relief and public health activities in the provinces during 1944-45

Province	Expenditure per capita in annas	Expenditure on medical relief and public health, expressed as a percentage of total provincial expenditure
Madras . . . . .	6.2	4.7
Bombay . . . . .	10.9	4.5
Bengal . . . . .	7.1	5.7
U. P. . . . .	3.9	4.9
Punjab . . . . .	6.1	5.1
Bihar . . . . .	3.2	7.3
C. P. and Berar . . . . .	2.8	3.1
Assam . . . . .	5.4	6.2
N.W. F. P. . . . .	7.7	5.0
Orissa . . . . .	3.4	5.9
Sind . . . . .	8.2	2.5

While a small number of items of existing expenditure in the provinces on health administration will fall within the cost of the scheme we have put forward, the vast majority of them will not and, broadly speaking, the expenditure involved in the execution of our proposals will be in addition to what the Governments, Central and Provincial, are now incurring on their medical and public health departments, which as shown above is generally on a meagre scale.

14. A reference to the last column of the above table will show that the expenditure incurred by Provincial Governments on health measures, curative and preventive, constitutes but a very small fraction of their total annual expenditure, the percentage ranging from 2.5 to 7.3. On the other hand, the corresponding percentage in Great Britain during 1934-35 was 20.4 and in the United States 13.8 during 1938. It is obvious that Governments in India have, in the past, devoted an unduly small proportion of their incomes to health administration and there is therefore every justification for demanding that the ratio of expenditure under this head must be raised considerably. Government should be prepared to increase the money spent on health to at least 15 per cent of the total expenditure. If this is done a considerable advance will have been made in providing the required funds for the proposed health programme. At least in one province (Madras) the local legislature has laid down (Section 127 of the Public Health Act) that every municipality "shall earmark not less than 30 per cent of its income from all sources other than Government grants, for expenditure on the advancement of public health in its local area, including expenditure on medical relief,

and every district board or panchayat shall similarly earmark not less than 12½ per cent of its income from such sources." We recommend that it should be a statutory obligation on Governments to spend a minimum of 15 per cent of their revenues on health activities.

15. The revenues of certain Provincial Governments have shown a marked increase during recent years. New sources of income, such as the sales tax, have been tapped and they have helped materially to increase the resources of the Governments concerned. We do not feel competent to discuss taxation policy or to recommend specific forms of raising revenue. We believe, however, that we are correct in holding that the existing resources of Governments can be augmented to a material extent and we recommend that Governments should make every effort to increase their revenues and to devote a substantial part of them to the development of the health and other programmes, which are essential for the betterment of national life and the increase of the nation's wealth.

16. This discussion of the ways in which Governments should attempt to solve the financial problem in connection with the implementation of the health programme will not be complete without attention being given to a matter to which reference was made earlier in this chapter, namely, the high cost of construction when it is carried out under the supervision of the Public Works Departments of Governments. We consider it highly desirable that a searching enquiry should be instituted into building costs and the data on which Public Works Departments base their estimates. Instances have been brought to our notice in which private agencies have been able to carry out new building work at less than 50 per cent of the estimates prepared by the Public Works Departments. We do not venture to base any criticism on such information, but there is undoubtedly a widespread and persistent belief that the Public Works Departments are unduly expensive agencies for the construction of public buildings. This calls for careful investigation, as considerations having far-reaching consequences for development in many spheres are involved.

17. In this connection we wish to draw attention to the report of a Mission which was sent to the United States of America by the Ministry of Works in the United Kingdom in 1944. The object of the Mission, which was an expert body, was to study American practice with a view to securing in Great Britain in the postwar period (a) increased speed and output, (b) reduced building costs, (c) improved standard of equipment and finish, and (d) improved conditions for operatives.

An enquiry into building methods and costs, with special reference to the Central and Provincial Public Works Departments in India will now be helpful, particularly if, with the enquiry, one or two of the representatives of His Majesty's Government's Mission to the United States were associated as well as some non-technical persons.

18. The need for the rapid development of public health and medical facilities is insistent. In our view it is a matter of vital importance that Governments should do their utmost to make the health services extend as far into the rural areas as circumstances permit, even though such an expansion might involve the utilisation, in the beginning, of improvised buildings which do not fulfil accepted standards. It is in the public interest that such limited financial resources as may be available should, in the early years, be spent

on personnel and equipment rather than on elaborate buildings, if money is not available for both. For instance a dispensary located in a mud hut can give useful and effective service, provided it is clean and sanitary.

Construction will, nevertheless, be necessary. Such construction should be the most economical compatible with the requirements essential for medical institutions. It should be planned so as to permit of future expansion, if required, and of such alterations as the progress of medical science may dictate. At all costs, elaborate and ornate buildings should be avoided.

19. In our view the short-term health programme set forth in the different chapters of this volume of the report provides the minimum standard of achievement in the different fields of health development, which Governments should keep before themselves as the objective to be attained within the first ten years of the execution of the scheme. The existing state of the public health in the country is so unsatisfactory that any attempt to improve the present position must necessarily involve administrative measures of such magnitude as may well seem to be out of all proportion to what has been conceived and accomplished in the past. This seems to us inevitable, especially because health administration has so far received from Governments but a fraction of the attention which it deserves in comparison with other branches of governmental activity. We believe that we have only been fulfilling the duty imposed on us by the Government of India in putting forward this health programme, which can in no way be considered as extravagant either in relation to the standards of health administration already reached in many other countries or in relation to the minimum requirements of any scheme which is intended to demonstrate an appreciable improvement in the health of the community. For reasons already set out, we also believe that the execution of the scheme should not be beyond the financial capacity of Governments.

20. We desire to stress the organic unity of the component parts of the programme we have put forward. Large-scale provision for the training of health personnel forms an essential part of the scheme, because the organisation of a trained army of fighters is the first requisite for the successful prosecution of the campaign against disease. Side by side with such training of personnel, we have provided for the establishment of a health organisation which will bring remedial and preventive services within the reach of the people, particularly of that vast section of the community which lies scattered over the rural areas and which has, in the past, been largely neglected from the point of view of health protection on modern lines. Considerations based on inadequacy of funds and insufficiency of trained workers have naturally necessitated the suggestion that the new organisation should first be established over a limited area in each district and later extended as and when funds and trained personnel become increasingly available. Even with such limitations the proposed health service is intended to fulfil, from the beginning and in an increasing measure as it expands, certain requirements which are now generally accepted as essential characteristics of modern health administration. These are that curative and preventive work should dovetail into each other and that, in the provision of such a combined service to the people, institutional and domiciliary treatment facilities should be so integrated as to provide the maximum benefit to the community.

There should also be provision in the health organisation for such consultant and laboratory services as are necessary to facilitate correct diagnosis and treatment. Our proposals incorporate these requirements of a satisfactory health service.

21. We have drawn attention to these aspects of the health programme because we feel that it is highly desirable that the plan should be accepted and executed in its entirety. We would strongly deprecate any attempt, on the plea of lack of funds, to isolate specific parts of the scheme and to give effect to them without taking into consideration the inter-relationships of the component parts of the programme. Our conception of the process of development of the national health services is that it will be a co-operative effort in which the Centre, acting with imagination and sympathy, will assist and guide a co-ordinated advance in the Provinces. We therefore look forward to a pooling of resources and of personnel, as far as circumstances permit, in the joint task that lies before the Governments.

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New Delhi, 18th December, 1945.

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\*With the proviso that he dissents from the section on population problem.

†With the reservation that he is unable to subscribe to some of the recommendations in the report.

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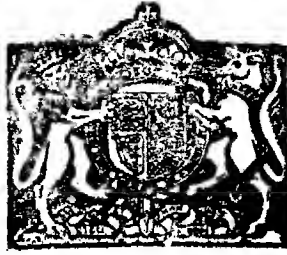
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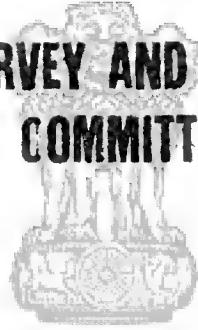
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**REPORT**  
**OF THE**  
**HEALTH SURVEY AND DEVELOPMENT**  
**COMMITTEE**



सत्यमेव जयते

**Vol. III**

**Appendices**

PRINTED BY THE MANAGER, GOVERNMENT OF INDIA PRESS, SIMLA.

1946.

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# APPENDIX I.

Statement showing average area and population of administrative units in the Provinces.

Name of Province.	No. of districts.	Area in sq. miles.	Per district			Range of Variation.	
			Population	Average area (in sq. miles)	Average population.	Area in sq. miles.	Population.
..	*24	*126,136	*48,564,329	*5,255.7	*2,023,514	989 to	209,709 to
..	19	76,443	20,840,840	4,023.3	1,097,360	153 to	261,147 to
..	†26	†77,408	†60,306,325	†2,867.0	†2,155,468	561 to	247,053 to
Provinces	48	106,247	55,020,617	2,213.3	1,146,263	976 to	266,244 to
..	30	99,089	28,418,819	3,303.0	947,294	80 to	38,576 to
..	16	69,745	36,340,151	4,359.1	2,271,259	2,164 to	912,734 to
..	19	98,575	16,813,584	5,177.6	884,925	2,435 to	438,342 to
C. P. and Berar	14	54,951	10,204,733	3,925.1	728,910	571 to	8,512 to
Assam	6	14,263	3,038,067	2,377.2	506,344	1,098 to	289,404 to
N.-W. F. P.	6	32,198	8,728,544	5,366.3	1,454,757	2,194 to	1,029,430 to
Orissa	8	48,136	4,535,008	6,017.0	566,876	1,969 to	304,034 to
Sind	6	54,456	501,631	9,076.0	83,605	407 to	6,009 to
Baluchistan	..	..	..	..	..	..	..

\*Excluding Madras city.

†Excluding Calcutta city.

APPENDIX 1—*contd.*

Name of Province.	Name of administ- rative unit.	Number of such units	Area (in. sq. miles)	Popula- tion	Average area (in sq. miles.)	Average popula- tion.
1	2	3	4	5	6	7
1. Madras .. ..	Taluk	233	125,790	48,764,329	530.9	209,289
2. Bombay .. ..	Taluk	186	76,443	20,849,840	411.0	112,096
3. C. P. and Berar .. ..	Tehsil	99	98,408	16,813,584	994.0	169,834
4. United Provinces .. ..	Tehsil	206	106,149	55,020,617	515.3	267,090
5. Punjab .. ..	Tehsil	115	91,571	28,418,819	796.3	247,120
6. N.-W. F. P. .. ..	Tehsil	18	13,518	3,038,067	751.0	168,781
7. Sind .. ..	Taluk	67	48,136	4,535,008	718.4	67,687
8. Orissa .. ..	{ Taluk*	21	17,532	2,983,126	834.8	142,054
	{ Thana	51	13,815	5,745,418	270.9	112,655
9. Bengal .. ..	Thana	609	77,442	60,306,525	127.2	99,025
10. Assam .. ..	Thana	131	55,043	10,204,733	420.2	77,899
11. Bihar .. ..	Thana	201	69,355	36,340,151	345.0	180,797

\*Taluk in respect of the portion taken from Madras Presidency & Thana in respect of that which was taken from "Bihar & Orissa."



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## APPENDIX 2.

## Long-term Programme.

*Staff and hospital accommodation in primary unit, secondary unit, and district headquarters organisation in the long-term programme.*

PRIMARY UNIT.			SECONDARY UNIT.		
Name		No.	Name.		No.
Controlling Officers .. ..	1		Administrative Officers .. ..	1	
Medical Officers .. ..	5		650-bed hospital :		
			Hheads of the sections of medi-		
			cine, surgery, maternity,		
			pathology & T. B. .. ..	5	
<i>Other staff :</i>			Medical Officers :		
Public health nurses .. ..	6		Senior visiting officers (Part-time)	20	
Midwives .. ..	6		Junior „ .. ..	12	
Sanitary inspectors .. ..	2		Resident M. O. .. ..	15	
Health assistants .. ..	2		Anaesthetists .. ..	15	
Fitter mistry .. ..	1		Pathologists .. ..	24	
Inferior servants .. ..	10		House staff .. ..	45	
<i>75-bed hospital :</i>					
<i>Nurses :</i>			<i>Nurses :</i>		
Matron .. ..	1		Matron .. ..	1	
Assistant Matron .. ..	1		Assistant Matron .. ..	1	
Night Sister .. ..	1		Sister Tutor .. ..	1	
Theatre Sister .. ..	1		Night Sister .. ..	1	
Ward Sisters .. ..	4		Theatre Sisters .. ..	3	
Staff Nurses .. ..	12		Ward O. P. & Special depart-		
			ment sisters .. ..	40	
Hospital social workers .. ..	3		Assistant night sister .. ..	1	
Ward attendants .. ..	8		Staff nurses .. ..	113	
Compounders .. ..	3		Home sister .. ..	1	
Cooks .. ..	3		Home keeper .. ..	1	
Kitchen servants .. ..	3		Hospital social workers .. ..	15	
Sweepers .. ..	8		Night staff nurses .. ..	2	
Mistry .. ..	1				
Malis .. ..	2		<i>Kitchen staff :</i>		
			Cooks .. ..	15	
			Servants .. ..	15	
			Sweepers .. ..	50	
			Mistry .. ..	2	
			Mali .. ..	5	
			<i>Other staff :</i>		
			Assistant Public Health En-		
			gineer .. ..	1	
			Senior public health nurses .. ..	2	
			Sanitary inspectors .. ..	2	
			Ward attendants .. ..	50	
			Compounders .. ..	25	
			<i>Clerical :</i>		
			Head clerk .. ..	1	
			Clerks .. ..	4	
			Statistical clerk .. ..	1	
			Typists .. ..	2	

**APPENDIX 2—contd.**  
**Long-term Programme—contd.**  
**District Headquarters Organisation.**

Name	No
<b>Administrative staff :</b>	
Officer in charge of district health services .. .. .	1
Deputies .. .. .	4 or 5
<b>2,500-bed Hospital :</b>	
Heads of sections of medicine, maternity, surgery and pathology ..	4
Research workers .. .. .	8
Research workers T. B. .. .. .	2
<b>Medical officers :</b>	
Senior medical officers .. .. .	28
Junior medical officers .. .. .	28
Resident M. O. .. .. .	30
Registrar & Anaesthetist .. .. .	23
Pathologist .. .. .	24
House staff .. .. .	116
<b>Nurses :</b>	
Matron Superintendent .. .. .	1
Matron .. .. .	3
Assistant Matron .. .. .	4
Sister Tutor .. .. .	4
Night Sister .. .. .	4
Theatre Sister .. .. .	12
Sister nurses (for ward O. P. & Special Deptt.) .. .. .	150
Assistant night sister .. .. .	4
Night staff nurse .. .. .	8
Staff nurse .. .. .	427
House sisters .. .. .	4
House keeper .. .. .	4
Hospital social worker .. .. .	50
Jamadar .. .. .	10
Ward attendants .. .. .	200
Pharmacist .. .. .	4
Compounders .. .. .	100
<b>Kitchen staff :</b>	
Head cook .. .. .	4
Cook .. .. .	60
Kitchen servants .. .. .	60
Mistry .. .. .	8
Sweepers .. .. .	200
Mali .. .. .	25
<b>Public Health Engineering :</b>	
Sanitary engineers .. .. .	2
Assistant sanitary engineers .. .. .	16
Draftsmen .. .. .	3
Inspector engineering .. .. .	2
Fitter mechanic .. .. .	1
Supervisory health visitor .. .. .	1
Supervisory sanitary inspector.. .. .	1
<b>Clerical staff :</b>	
Head clerk .. .. .	1
Accountant .. .. .	1
Asst. accountant .. .. .	2
Clerks .. .. .	16
Statistical clerk .. .. .	4

## APPENDIX 3.

## Short-term Programme.

*Staff of a 200-bed hospital and the administrative organisation in a secondary unit.*

Name	No.	Scale of pay.
		Rs.
Superintendent .. .. .	1	500—30—800
M. O.'s in-Charge of Departments of Medicine, Surgery, mid-wifery & Gynaecology .. .. .	2	400—30—700
M. O. in-Charge of Laboratory .. .. .	1	400—30—700
House staff .. .. .	6	250—25—500
Assistant M. O. in charge of Laboratory .. .. .	2	250—25—500
Part-time Doctors .. .. .	3	100 p.m.
Matron .. .. .	1	200—10—300
Assistant Matron .. .. .	1	150—5—200
Sister Tutor .. .. .	1	140—5—190
Night Sister .. .. .	1	135—5—185
Theater Sisters .. .. .	2	125—5—175
Ward Sisters .. .. .	4	115—5—165
Staff Nurses .. .. .	19	100—5—175
Staff Nurses .. .. .	17	75—5—125
Night Staff Nurses .. .. .	2	75—5—125
House Sister .. .. .	1	100—5—150
House keeper .. .. .	1	100—5—150
Senior pharmacist .. .. .	1	60—3—90
Laboratory technicians .. .. .	3	60—5—100
Caretaker .. .. .	1	40—2—60
Laboratory attendants .. .. .	3	30—2—50
Pharmacist .. .. .	6	40—2—60
Ward attendants .. .. .	16	30—2—50
Sweepers .. .. .	16	25—1—35
Cooks .. .. .	8	30—2—50
Mali .. .. .	4	25—1—35
Mistry .. .. .	1	40—2—60
Clerk .. .. .	1	150—10—250
Stenographer .. .. .	1	100—5—200
Clerk .. .. .	1	75—5—150
Peons .. .. .	2	25—2—55
<b>X-Ray Staff :</b>		
Senior M. O (X-Ray) .. .. .	1	400—30—700
Assistant M. O. (X-Ray) .. .. .	1	250—25—50
Technician .. .. .	1	150—10—250
Nurse .. .. .	1	100—5—150
	1	75—5—150
	2	25—2—55
<b>Attendants</b> .. .. .		
<b>Dental Service :</b>		
Orthodontal Surgeon .. .. .	1	375—25—750
Dentists .. .. .	2	250—25—500
Dental hygienists .. .. .	4	80—5—130

*Administrative organisation in a secondary unit.*

Name	No.	Scale of pay.
		Rs.
Administrative Medical Officer .. .. .	1	1,000—50—1,200
Deputy Administrative Medical Officer .. .. .	1	500—30—800
Assistant Administrative Medical Officer (Maternity and Child Welfare) .. .. .	1	400—30—700
Assistant Public Health Engineer .. .. .	1	400—30—700
Senior Sanitary Inspectors .. .. .	2	150—10—250
Senior Public Health Nurses .. .. .	2	150—10—250
Head Clerk .. .. .	1	200—10—300
Statistical Clerk .. .. .	1	200—10—300
Stenographers .. .. .	3	100—5—200
Clerk (1st Division) .. .. .	1	150—10—250
Clerks (2nd Division) .. .. .	2	75—5—150
Inferior servants .. .. .	5	25—2—55
Dentist .. .. .	1	250—25—500
Dental Hygienists .. .. .	2	80—5—130
Attendant .. .. .	1	30—2—60



## APPENDIX 4.

*The Population of individual provinces covered by the scheme at the end of first five and ten years.*

					End of five years.	End of ten years.
1. Madras	..	..	..	..	9,600,000	25,920,000
2. Bombay	..	..	..	..	7,600,000	11,400,000
3. Bengal	..	..	..	..	10,400,000	31,200,000
4. U. P.	..	..	..	..	19,200,000	28,800,000
5. Bihar	..	..	..	..	6,400,000	18,560,000
6. Orissa	..	..	..	..	2,400,000	4,560,000
7. Punjab	..	..	..	..	10,800,000	16,800,000
8. C. P. & Berar	..	..	..	..	6,080,000	9,120,000
9. Assam	..	..	..	..	2,800,000	5,600,000
10. Sind	..	..	..	..	1,600,000	2,560,000
11. N.-W. F. P.	..	..	..	..	1,200,000	1,680,000
Total					78,080,000	156,200,000



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## APPENDIX 5.

*A suggested scheme of implementation of the programme in individual provinces during the first ten years.*

MADRAS (24 DISTRICTS).

1941 Population 48·56 millions.

PRIMARY UNITS.					SECONDARY UNITS.		
Year.	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year	5	200,000	5	1	1	1	..
2nd "	5	200,000	5	1	1	1	..
3rd "	5	200,000	5	1	1	1	..
4th "	7	280,000	7	2	1	1	..
5th "	10	400,000	10	2	1	1	..
6th "	13	520,000	13	4	1	1	..
7th "	16	640,000	16	6	2	1	1
8th "	19	760,000	19	8	2	1	1
9th "	23	920,000	23	11	2	1	1
10th "	27	1,080,000	27	14	2	1	1

BOMBAY (91 DISTRICTS).

1941 Population 20·85 millions.

PRIMARY UNITS.					SECONDARY UNITS.		
Year.	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year	5	200,000	5	1	1	1	..
2nd "	5	200,000	5	1	1	1	..
3rd "	5	200,000	5	1	1	1	..
4th "	7	280,000	7	2	1	1	..
5th "	10	400,000	10	2	1	1	..
6th "	11	440,000	11	3	1	1	..
7th "	12	480,000	12	4	1	1	..
8th "	13	520,000	13	5	1	1	..
9th "	14	560,000	14	7	1	1	..
10th "	15	600,000	15	8	2	1	..

## APPENDIX 5--contd.

**BENGAL (26 DISTRICTS).**

1941 Population 60.31 millions.

PRIMARY UNITS.					SECONDARY UNITS.		
Year.	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year	5	200,000	5	1	1	1	..
2nd "	5	200,000	5	1	1	1	..
3rd "	5	200,000	5	1	1	1	..
4th "	7	280,000	7	2	1	1	..
5th "	10	400,000	10	2	1	1	..
6th "	14	560,000	14	4	1	1	..
7th "	18	720,000	18	6	2	1	1
8th "	22	880,000	22	8	2	1	1
9th "	26	1,040,000	26	11	2	1	1
10th "	30	1,200,000	30	15	2	1	1



UNITED PROVINCES (48 DISTRICTS).

1941 Population 55.02 millions

PRIMARY UNITS.					SECONDARY UNITS.		
Year.	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year	5	200,000	5	1	1	1	..
2nd "	5	200,000	5	1	1	1	..
3rd "	5	200,000	5	1	1	1	..
4th "	7	280,000	7	2	1	1	..
5th "	10	400,000	10	2	1	1	..
6th "	11	440,000	11	3	1	1	..
7th "	12	480,000	12	4	1	1	..
8th "	13	520,000	13	5	1	1	..
9th "	14	560,000	14	6	1	1	..
10th "	15	600,000	15	8	2	1	1

APPENDIX 5—*contd.*

BIHAR (16 DISTRICTS).

1941 Population 36.34 million.

Year	PRIMARY UNITS.				SECONDARY UNITS.		
	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year	5	200,000	5	1	1	1	
2nd "	5	200,000	5	1	1	1	
3rd "	5	200,000	5	1	1	1	
4th "	7	280,000	7	2	1	1	
5th "	10	400,000	10	2	1	1	
6th "	13	520,000	13	4	1	1	
7th "	17	680,000	17	6	2	1	1
8th "	21	840,000	21	8	2	1	1
9th "	25	1,000,000	25	11	2	1	1
10th "	29	1,160,000	29	14	2	1	1

ORISSA (6 DISTRICTS).

1941 Population 8.73 million.

Year.	PRIMARY UNITS.				SECONDARY UNITS		
	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year	5	200,000	5	1	1	1	
2nd "	5	200,000	5	1	1	1	
3rd "	5	200,000	5	1	1	1	
4th "	7	280,000	7	2	1	1	
5th "	10	400,000	10	2	1	1	
6th "	11	440,000	11	3	1	1	
7th "	13	520,000	13	4	1	1	
8th "	15	600,000	15	6	2	1	1
9th "	17	680,000	17	8	2	1	1
10th "	19	760,000	19	10	3	1	1

APPENDIX 5—*contd.*

PUNJAB (30 DISTRICTS).

1941 Population 28.42 millions.

PRIMARY UNITS.					SECONDARY UNITS.		
Year.	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year ..	5	200,000	5	1	1	1	..
2nd ..	5	200,000	5	1	1	1	..
3rd ..	5	200,000	5	1	1	1	..
4th ..	7	280,000	7	2	1	1	..
5th ..	9	360,000	9	2	1	1	..
6th ..	10	400,000	10	3	1	1	..
7th ..	11	440,000	11	4	1	1	..
8th ..	12	480,000	12	5	1	1	..
9th ..	13	520,000	13	6	1	1	..
10th ..	14	560,000	14	7	1	1	..

CENTRAL PROVINCES &amp; BEHAR (19 DISTRICTS).

1941 Population 16.81 millions.

PRIMARY UNITS.					SECONDARY UNITS.		
Year.	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year ..	5	200,000	5	1	1	1	..
2nd ..	5	200,000	5	1	1	1	..
3rd ..	5	200,000	5	1	1	1	..
4th ..	7	282,000	7	2	1	1	..
5th ..	8	320,000	8	2	1	1	..
6th ..	8	320,000	8	2	1	1	..
7th ..	9	360,000	9	3	1	1	..
8th ..	10	400,000	10	4	1	1	..
9th ..	11	440,000	11	5	1	1	..
10th ..	12	480,000	12	6	1	1	..

APPENDIX 5—*contd.*

ASSAM (14 DISTRICTS).

1941 Population 10.20 millions.

PRIMARY UNITS.					SECONDARY UNITS.		
Year.	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year ..	5	200,000	5	1	1	1	..
2nd ..	5	200,000	5	1	1	1	..
3rd ..	5	200,000	5	1	1	1	..
4th ..	5	200,000	5	1	1	1	..
5th ..	5	200,000	5	1	1	1	..
6th ..	6	240,000	6	1	1	1	..
7th ..	7	280,000	7	2	1	1	..
8th ..	8	320,000	8	3	1	1	..
9th ..	9	360,000	9	4	1	1	..
10th ..	10	400,000	10	5	1	1	..

SIND (8 DISTRICTS).

1941 Population 4.64 millions.

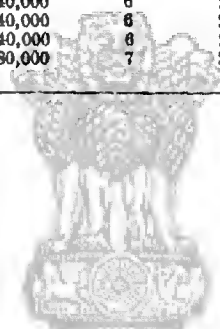
PRIMARY UNITS.					SECONDARY UNITS.		
Year.	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals.
1st Year ..	5	200,000	5	1	1	1	..
2nd ..	5	200,000	5	1	1	1	..
3rd ..	5	200,000	5	1	1	1	..
4th ..	5	200,000	5	1	1	1	..
5th ..	5	200,000	5	1	1	1	..
6th ..	5	200,000	5	1	1	1	..
7th ..	6	240,000	6	2	1	1	..
8th ..	6	240,000	6	2	1	1	..
9th ..	7	280,000	7	3	1	1	..
10th ..	8	320,000	8	4	1	1	..

APPENDIX 5—*contd.*

W. F. P. (6 Districts).

1941 Population 3·04 millions

PRIMARY UNITS.			SECONDARY UNITS.				
Year.	No. of Primary units (40,000 population) in a district.	Population served.	No. of dispensaries in primary units each having two emergency and two maternity beds.	No. of 30-bed hospitals in primary units.	No. of Secondary units.	No. of 200-bed hospitals in secondary units.	No. of 500-bed hospitals
1st Year ..	5	200,000	5	1	1	1	..
2nd .. ..	5	200,000	5	1	1	1	..
3rd .. ..	5	200,000	5	1	1	1	..
4th .. ..	5	200,000	5	1	1	1	..
5th .. ..	5	200,000	5	1	1	1	..
6th .. ..	5	200,000	5	1	1	1	..
7th .. ..	6	240,000	6	2	1	1	..
8th .. ..	6	240,000	6	2	1	1	..
9th .. ..	6	240,000	6	2	1	1	..
10th .. ..	7	280,000	7	3	1	1	..

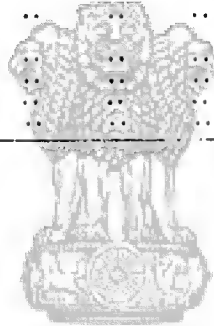


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## APPENDIX 6.

*Total provision of hospital beds of all types at the end of the first five and ten years.*

					End of first five years.	End of first ten years.
<b>General beds—</b>						
1. Primary unit dispensaries .. .. .	..	..	..	..	7,808	15,620
2. Thirty-bed hospitals .. .. .	..	..	..	..	12,120	59,700
3. 200-bed hospitals .. .. .	..	..	..	..	43,200	43,200
4. 500-bed hospitals .. .. .	..	..	..	..	..	69,500
5. Medical colleges .. .. .	..	..	..	..	17,000	32,600
					80,128	220,620
Tuberculosis beds .. .. .	..	..	..	..	6,600	13,200
					86,728	233,820
Leprosy .. .. .	..	..	..	..	14,000	28,000
					100,728	261,820
Mental beds .. .. .	..	..	..	..	9,000	18,000
					109,728	279,820
Existing .. .. .	..	..	..	..	73,000	73,000
					182,782	352,820
Total .. .. .	..	..	..	..	183,000	353,000
Aproximately .. .. .	..	..	..	..	330 millions	345 millions.
Population .. .. .	..	..	..	..	0.55	1.03
Rate per 1,000 population .. .. .	..	..	..	..		



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## APPENDIX 7.

*A provincial nutrition organisation.*

	Name.	No.	Scale.
<i>Staff—</i>			
	Chief Nutrition Officer .. .. .	1	Rs. 600—40—1,000.
<i>Field—</i>			
	Field workers .. .. .	3	Rs. 300—20—500.
	Inferior servants .. .. .	3	Rs. 25—2—55.
<i>Laboratory—</i>			
	Chief Assistant .. .. .	1	Rs. 300—20—500.
<i>(Chemistry &amp; Biochemistry)</i>			
	Chemist .. .. .	1	Rs. 150—10—250
	Laboratory assistants .. .. .	3	Rs. 50—5—100.
	Animal attendants .. .. .	3	Rs. 25—2—55.
	Inferior servants .. .. .	3	Rs. 25—2—55.
<i>Office—</i>			
	Stenographer .. .. .	1	Rs. 75—5—150.
	Typist clerks .. .. .	2	Rs. 60—5—100.
	Statistician .. .. .	1	Rs. 150—10—250.
	Artist .. .. .	1	Rs. 100—5—150.
	Inferior servants .. .. .	2	Rs. 25—2—55.



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## APPENDIX 8.

*A. provincial venereal diseases organisation and its expenditure.**Details of Expenditure.**1. Provincial organisation—*

			1st five years.	Ten years.
			Rs.	Rs.
1st year.	..	1,80,696		
2nd "	..	1,83,898		
3rd "	..	1,87,081		
4th "	..	1,90,273		
5th "	..	1,93,446	$9,35,394 \times 11 = 1,02,89,334$	
6th "	..	1,97,108		
7th "	..	2,00,317		
8th "	..	2,03,948		
9th "	..	2,06,738		
10th "	..	2,09,949	$19,53,454 \times 11 =$	2,14,87,004

*2. District organisation—*

1st year	..	13,497		
2nd "	..	14,039		
3rd "	..	14,582		
4th "	..	15,125		
5th "	..	15,668	$72,911 \times 216 = 1,57,48,776$	
6th "	..	16,382		
7th "	..	16,934		
8th "	..	17,485		
9th "	..	18,037		
10th "	..	18,589	$1,60,338 \times 216 =$	3,46,33,008

*3. Purchase of Drugs—*

1st year	..	4,000		
2nd "	..	4,000		
3rd "	..	4,000		
4th "	..	6,000		
5th "	..	8,000	$28,000 \times 216 = 56,16,000$	
6th "	..	10,400		
7th "	..	12,800		
8th "	..	15,200		
9th "	..	18,400		
10th "	..	21,600	$1,04,400 \times 216 =$	2,25,50,400

Total ..

3,16,54,110 7,86,71,402

## STAFF.

	Name.	No.	Scale.
<i>1. Provincial Organisation—</i>			
	Officer in charge .. .. .	1	Rs. 600—40—1,000.
	Assistant officers in charge .. .. .	2	Rs. 500—30—800.
	Propaganda officer .. .. .	1	Rs. 350—25—500.
	Social worker supervisor .. .. .	1	Rs. 250—25—500.
	Propaganda workers .. .. .	8	Rs. 100—5—150.
	Clerks .. .. .	3	Rs. 100—5—200.
	Accountant .. .. .	1	Rs. 150—5—250.
	Stenographers .. .. .	2	Rs. 100—5—200.
	Inferior servants .. .. .	2	Rs. 25—2—55.
<i>2. District clinic organisation—</i>			
	Medical officer .. .. .	1	Rs. 250—25—500.
	Social worker .. .. .	1	Rs. 125—5—150.
	Clerk .. .. .	1	Rs. 100—5—200.
	Peon .. .. .	1	Rs. 25—2—55.
	Sweeper .. .. .	1	Rs. 25—1—35.
<i>3. Provision for purchase of drugs—</i>			

## APPENDIX 9.

## ESTIMATES OF EXPENDITURE ON MENTAL INSTITUTIONS.

*First five years.*

(1) Improvements in mental hospitals.	Non-recurring Rs.	Recurring Rs.
(a) Madras .. .. .	10,00,000	
(b) Poona .. .. .	10,00,000	
(c) Agra .. .. .	25,00,000	
(d) Nagpur .. .. .	25,00,000	
(e) Lahore		
(new hospital 1,500 beds) .. .. .	50,00,000	
(f) Ranchi		
(European Mental Hospital) .. .. .	10,00,000	
(g) Ranchi		
(Indian Mental Hospital) .. .. .	10,00,000	
(h) Thana		
(Converted into Mental Deficiency or Senile		
Home) .. .. .	5,00,000	
	<u>1,45,00,000</u>	
(2) Opening of two new mental hospitals in Bombay & Calcutta .. .. .	22,00,000	
	<u>1,67,00,000</u>	
(3) Beds—9,000 (Total number in all the above eight mental hospitals including 2 new ones) @ Rs. 1,000/- per bed $\times$ 5 years .. .. .		4,50,00,000
(4) Training of nurses in mental hospitals—2 years course—100 nurses to be admitted for training each year. Total number of nurses that require stipends etc. in first five years=900, @ 75/- per month 900 $\times$ 75 $\times$ 12 months .. .. .		8,10,000
(5) Training of doctors in the United Kingdom 20 $\times$ 8,000 $\times$ 5		8,00,000
Doctors.		
(6) Salaries of Central and Provincial Mental Officers :—		
Centre .. .. .		1,66,560
Provinces .. .. .		8,80,550
(7) Maintenance charges of hospital works .. .. .		10,02,000
Total (recurring) .. .. .		<u>4,86,59,110</u>

APPENDIX 9—*contd.*

## ESTIMATES OF EXPENDITURE ON MENTAL INSTITUTIONS.

*Second five years.*

(1) Improvements to the remaining mental hospitals : Non-recurring			(Rs.)	Recurring.	(Rs.)
(a) Ahmedabad (500 beds)	..	..	..	} @ Rs. 10,00,000 per hospital 10,00,000 × 9 =	
(b) Ratnagiri	..	..	..		
(c) Dharwar	..	..	..		
(d) Calicut	..	..	..		
(e) Waltair	..	..	..		
(f) Bareilly—(100 beds)	..	..	..		
(g) Benares	..	..	..		
(h) Hyderabad (Sind)	..	..	..		
(i) Assam—(1,000 beds)	..	..	..		
					90,00,000
(2) Opening of five new mental hospitals in Madras, Punjab, U.P., Bihar and Central Provinces, each with 500 beds, @ Rs. 22 lakhs per hospital for building and equipment			..	..	1,10,00,000
(3) Increasing the bed strength of the two new mental hospitals in Calcutta and Bombay, started in the first five years, from 200 to 500 beds			..	..	22,00,000
Total (non-recurring)			..	Rs.	2,22,00,000
<i>Recurring :—</i>					
(4) Total beds	(1st five years	2nd five years)			
	9,000	+ 9,000			
		= 18,000			
@ Rs. 1,000 per bed per year for five years	..	..	..	..	9,00,00,000
(5) Training of nurses—50 nurses to be admitted each year for two years course. Each nurse gets Rs. 75 p.m. as stipend during training 550 × 75 × 12 =			..	..	4,95,000
(6) Training of doctors : 20 × 8,000 × 5 =			..	..	8,00,000
(7) Salaries of Central and Provincial Mental Officers attached to the respective health organisations			..	..	
				Centre	1,73,460
				Provinces	10,32,350
(8) Maintenance charges on capital works			..	..	38,37,000
Total (recurring)			..	..	9,63,37,810
Grand Total (recurring) of the 1st ten years			..	..	14,49,96,920

## APPENDIX 9—concd.

*Mental Health Organisation.*

(Further details.)

*Centre :*

	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
<i>Mental Officer at the Centre @ Rs.</i>										
1,900—50—2,100 ..	22,800	23,400	24,000	24,600	25,200	25,200	25,200	25,200	25,200	25,200
Pension @ Rs. 176 p.m. ..	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112
Leave salary @ 15 p.c. ..	3,420	3,510	3,600	3,690	3,780	3,780	3,780	3,780	3,780	3,780
Allowances ..	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600
<b>Total</b>	51,952	52,622	53,312	54,002	54,692	54,692	54,692	54,692	54,692	54,692

Rs. 1,60,560.

Rs. 1,73,460.

Rs. 3,40,620.

*Provinces :**Provincial Mental Officer @*

Rs. 600—40—1,600 plus

250 p.m. as special pay

Pension @ Rs. 98 p.m.

Leave salary @ 15 p.c.

Allowances ..

**Total**

..	7,200	7,680	8,160	8,640	9,120	9,600	10,080	10,560	11,040	11,520
..	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
..	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176
..	1,530	1,602	1,674	1,746	1,818	1,890	1,962	2,034	2,106	2,178
..	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
<b>Total</b>	14,906	15,458	16,010	16,562	17,114	17,666	18,218	18,770	19,322	19,874

1st five years. Rs. 80,050.

Second five years. Rs. 93,850.

1st ten years. Rs. 1,73,900.

Rs.

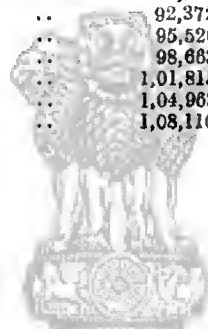
1st five years :  $80,050 \times 11 = 8,80,550$  } 1st ten years = Rs. 19,12,900.Second five years :  $93,850 \times 11 = 10,32,350$  }*For eleven Provinces :*

**APPENDIX 10.**  
**ESTIMATES OF EXPENDITURE ON LEPROSY ORGANIZATIONS.**

<i>Leprosy (Centre).</i>				1st five years.	1st ten years.
Central Leprosy Institute .. ..				Rs.	Rs.
Non-recurring expenditure .. ..	..	..	..	5,00,000	5,00,000
<i>Recurring :</i>					
Maintenance @ 3 p.o. per year on the above capital works .. ..	..	..	..	30,000	1,05,000
*Annual recurring cost including salaries of staff, etc. .. ..	..	..	..	4,30,386	9,39,462
Total (recurring) ..				4,60,386	10,44,462

\*Annual recurring cost from year to year :

				Rs.	1st 5 years.	1st ten years.
1st year .. ..	..	..	..	79,782		
2nd year .. ..	..	..	..	82,030		
3rd year .. ..	..	..	..	86,077		
4th year .. ..	..	..	..	89,223		
5th year .. ..	..	..	..	92,372	4,30,386	
6th year .. ..	..	..	..	95,520		
7th year .. ..	..	..	..	98,663		
8th year .. ..	..	..	..	1,01,815		
9th year .. ..	..	..	..	1,04,963		
10th year .. ..	..	..	..	1,08,110		9,39,462



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**APPENDIX 10—contd.**  
**Staff of the Central Leprosy Institute (Further details).**

	No.	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.	
Chief @ 1,250-50-1,750	..	1	15,000	15,600	16,200	16,800	17,400	18,000	18,600	19,200	19,800	20,400
Senior Assistants—@ Rs. 800—40—1,200	..	2	19,200	20,160	21,120	22,080	23,040	24,000	24,960	25,920	26,880	27,840
Junior Assistants—@ Rs. 600—30—900	..	2	14,400	15,120	15,840	16,560	17,280	18,000	18,720	19,440	20,160	20,880
Social worker—@ Rs. 375-25-750	1	4,500	4,800	5,100	5,400	5,700	6,000	6,300	6,600	6,900	7,200	7,500
Other staff including ministerial staff including contingencies @ Rs. 15,000 per year	..	..	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000
Pension & leave salary charges .	..	..	11,682	12,250	12,817	13,385	13,952	14,520	15,088	15,655	16,223	16,790
Total Rs.	..	..	79,782	82,930	86,077	89,225	92,372	95,520	98,668	1,01,815	1,04,963	1,08,110

**37,80,000**



## APPENDIX 10—concl'd.

(b)			New beds.		Total beds.	Total maintenance charges.	
						Rs.	
1st year	2,800	..	..	2,800	11,20,000		
2nd year	2,800	..	..	5,600	22,40,000		
3rd year	2,800	..	..	8,400	33,60,000		
4th year	2,800	..	..	11,200	44,80,000	Rs.	
5th year	2,800	..	..	14,000	56,00,000	1,68,00,000	
6th year	2,800	..	..	16,800	67,20,000		
7th year	2,800	..	..	19,600	78,40,000		
8th year	2,800	..	..	22,400	89,60,000		
9th year	2,800	..	..	25,200	1,00,80,000	Rs.	
10th year	2,800	..	..	28,000	1,12,00,000	6,16,00,000	

(c) Details of annual expenditure on Provincial Leprosy Organisations.			Rs.	
1st year	..	..	..	62,333
2nd year	..	..	..	65,553
3rd year	..	..	..	67,554
4th year	..	..	..	70,764
5th year	..	..	..	73,975
				$\frac{340,179 \times 11 \times 2}{3} = 24,94,646$
6th year	..	..	..	77,644
7th year	..	..	..	80,871
8th year	..	..	..	84,320
9th year	..	..	..	87,328
10th year	..	..	..	90,557
				$\frac{7,60,899 \times 11 \times 2}{3} = 55,79,928$

(d)	$5000 \times 11 \times 5$			= 2,75,000
	1st ten years $2,75,000 + 2,75,000$	..	..	= 5,50,000
(e)	1st five years $= 10,000 \times 125 \times 5$			= 62,50,000
	2nd five years $= 20,000 \times 125 \times 5$			= 1,25,00,000
	Total ten years ..	1,25,00,000 + 62,50,000		= 1,87,50,000
(f)	1st five years ..	$3,00,000 \times 5$		= 15,90,000
	Ten years ..	$15,00,000 + 15,00,000$		30,00,000

## APPENDIX 11.

ESTIMATE OF DOCTORS REQUIRED AT THE END OF FIRST FIVE YEARS  
AND FIRST TEN YEARS.*Medical Colleges :*

First five years.                      First  
ten years.

The estimate for a medical college has been based on the suggestions put forward by the Goodenough Committee, namely, for preclinical subjects 69 and for clinical subjects 119 in each college.

Total required .. .. .	188×24	=4,512	43×188	=8,084
<i>Primary Unit :</i>				
2 Doctors for each primary unit ..	2×1952	=3,904	2×3905	=7,810
✓ 30 Bed hospital: 1 Doctor each ..	1×404	=404	1×1990	=1,990
<i>Secondary Unit :</i>				
3 M.O.'s for each secondary unit ..	3×216	=648	3×355	=1,065
200 Bed hospitals: 15 Doctors for each ..	15×216	=3,240	15×216	=3,240
500 Bed hospital .. .. .	..	..	15×139	=2,085
Mobile, dental organisations .. .. .	..	..	1×355	=355
District headquarters organisation: two doctors for each .. .. .	2×216	=432	..	=432
<i>Central Directorate :</i> .. .. .	..	21	..	21
<i>Provincial Directorate :</i> .. .. .	20×11	=220	..	220
<i>Tuberculosis :</i>				
5 Doctors for each 200-bed hospital				
1 : 40 .. .. .	5×33	=165	5×66	=330
Main clinics 3 for each .. .. .	3×33	=99	3×66	=198
District clinics: 2 for each .. .. .	2×183	=366	2×366	=732
Travelling tuberculosis clinics .. .. .	..	..	1×710	=710
<i>Mental diseases :</i>				
1 Doctor for 50 beds: 9,000 new beds in each period .. .. .	..	180	..	360
<i>Malaria :</i>				
Headquarters .. .. .	..	44	..	44
Deputies .. .. .	..	..	..	22
Control Unit, 10 for each province ..	10×11	=110	25×11	=275
<i>Leprosy :</i>				
14,000 beds, 1 doctor for 40 .. .. .	..	350	..	700
<i>Venereal diseases :</i>				
Provinces .. .. .	5×11	=55	10×11	=110
Districts .. .. .	1×216	=216	2×216	=432
<i>School health :</i>				
2 for each province .. .. .	2×11	=22	4×11	=44
<i>Nutrition :</i>				
5 for each Province .. .. .	5×11	=55	..	55
<b>Totals :</b>		<b>15,043</b>		<b>29,314</b>

## APPENDIX 12.

*Estimate of nurses for hospitals and dispensaries required at the end of first five and first ten years.*

	<i>First five years.</i>		<i>First ten years.</i>
Primary units dispensaries .. ..	$1952 \times 1 =$	1,952	$3905 \times 1 = 3,905$
30-bed hospitals : 8 nurses per hospital	$404 \times 8 =$	3,232	$1990 \times 8 = 15,920$
<i>Secondary Unit.</i>			
200 bed hospitals 50 nurses per hospital	$216 \times 50 =$	10,800	$216 \times 50 = 10,800$
500 bed hospitals 125 nurses per hospital	..	..	$139 \times 125 = 17,375$
<i>Hospitals attached to Medical Colleges.</i>			
1,000 beds in each and 250 nurses ..	$250 \times 24 =$	6,000	$250 \times 43 = 10,750$
<i>Tuberculosis.</i>			
200 bed hospital for every centre, each hospital will have 20 nurses ..	$33 \times 20 =$	660	$66 \times 20 = 1,320$
Travelling tuberculosis clinics : One nurse in each .. .. .	..	Nil	$710 \times 1 = 710$
<i>Mental.</i>			
9,000 new beds in each period, 1 nurse for 20 beds .. .. .	..	450	900
<i>Leprosy.</i>			
To provide for 14,000 beds in each period : 1 nurse for 20 beds .. .. .	..	700	1,400
	<b>Totals</b>	<b>23,794</b>	<b>83,080</b>

*Public health nurses for outdoor duty.*

<i>Primary Unit.</i>			
Public health nurses per unit ..	$1952 \times 4 =$	7,808	$3905 \times 4 = 15,620$
<i>Secondary Unit.</i>			
2 Senior public health nurses per unit ..	$216 \times 2 =$	432	$355 \times 2 = 710$
<i>Tuberculosis.</i>			
Three public health nurses for every main clinic	$33 \times 3 =$	99	$66 \times 3 = 198$
Two for every district clinic .. ..	$183 \times 2 =$	366	$366 \times 2 = 732$
<i>School Health.</i>			
1 Senior public health nurses for every Province	$11 \times 1 =$	11	$22 \times 1 = 22$
	<b>8,716</b>		<b>17,282</b>
Total number of nurses required ( public health nurses and hospital nurses) .. ..		<b>32,510</b>	<b>80,362</b>

## APPENDIX 13.

## NURSERIES IN THE SOVIET UNION.

(Extract from Professor Henry E. Sigerist's book "*Socialised Medicine in the Soviet Union*".)

The Soviet nursery serves a three-fold purpose. It liberates the working woman, it cares for the child, and it educates the child as well as the mother. The director of the nursery is generally a woman physician and the staff consists of doctors, psychologists, and nurses. Most nurseries have a capacity of from about 50 to 125 children. They are organised in three divisions: one for the infants under one year, one for children in the second year, and one for those in the third year. Some nurseries are operated in shifts according to the working hours of the mothers.

Today the equipment and routine of Soviet nurseries are more or less standardised and similar institutions are found in Moscow and in the Caucasus, as well as in Central Asia and Siberia. On her way to work the mother brings her child to the nursery, undresses him, puts the clothes in a locker, and delivers the nude child to a nurse who weighs him and gives him to the pediatrician for a routine examination. The temperature is taken and if any symptoms are discovered, the child is brought to the infirmary or, in case of more serious illness, to the hospital. If a child is found to be dirty and neglected, the mother and child are sent home and a visiting nurse goes to inspect it. Once in the nursery, the child is dressed in nursery clothing and joins the children of his age. Small infants are kept in cribs; they have toys to play with, and at regular intervals the mothers come to nurse them. The mother removes her working dress, and puts on a sterilised gown especially made for the purpose with slits at the breasts. After having fed the child, the mother receives her own lunch in the nursery free of charge. In such a way a very close co-operation develops between the nursery workers and the mothers, who are in daily contact with pediatricians. In the nurseries, mothers learn how a child should properly be dressed and fed. They learn that fresh air is not harmful to children, as was believed for centuries and is still believed in many parts of Europe. Home visitors inspect the living places regularly in order to find out under what conditions the children live.

Once a child begins to crawl, he enters the second group. He then plays in the pen and has a different set of toys. Gradually he is taught to develop certain habits, such as bathing and eating. He learns to urinate and go to the stool at definite times. Special tables accommodating three children have been devised for meals, on the assumption that one nurse can feed three children. Eating in groups also develops a certain spirit of co-operation for regardless of how greedy a child may be, he soon learns that he has to await his turn. At the age of one year and nine months a child is expected to be able to undress alone and at the age of two and a half years he is expected to make his own bed and to dress himself. Part of the standard equipment of every nursery is a staircase and slide. At the age of two the child is expected to be able to walk upstairs, and at two years and nine months, to walk downstairs without holding on to the banister. Older children play in groups; their toys are automobiles, locomotives, aeroplanes, tractors, besides, of course, dolls and teddy bears. They sing and dance.

Whenever possible, they play out-of-doors shovelling snow, and chopping wood. In the summer many nurseries are moved to the country. The children are brought in contact with nature and labour, and there is no more touching sight than to see a brigade of youngsters watching a herd of cattle or observing the work of a tractor and listening to an explanation of its use.

At the age of three the child leaves the nursery as an independent little citizen, who is healthy in mind and body and does not have to rely on adults in his daily living habits. During these three years the mother has had a thorough education that will prove valuable to her in rearing later children.

## APPENDIX 14.

### *Provincial Malaria Organisation.*

#### *(a) Provincial Headquarters staff:*

First five years.				Second five years.	
Assistant Director of Health Services (Malariaology)			1	The same staff.	
Entomologist .. .. .	..	..	1		
Sanitary Engineer .. .. .	..	..	1		
Overseers .. .. .	..	..	4		
Draftsman .. .. .	..	..	1		
Antimalaria Officer .. .. .	..	..	1		
Laboratory Assistants .. .. .	..	..	5		
Antimalaria Assistants .. .. .	..	..	2		
Clerks .. .. .	..	..	3		
Insect collectors .. .. .	..	..	8		
Inferior servants .. .. .	..	..	2		
Sweepers .. .. .	..	..	2		

(b) *Regional Organisation.*—While five Deputy Assistant Directors are eventually to be provided in all the major provinces none will be appointed during the first five years and only two such posts will be created during the second five years.

#### First five years.

Nil

#### Second five years.

##### Deputy Assistant Directors of

Health .. .. .	2
Clerks .. .. .	2

#### *(c) Malaria Control Units :*

Staff of one unit :—				Number of malaria control units to be established during the	
				First five years.	Second five years.
Antimalaria assistant .. .. .	..	..	1		
Laboratory assistants .. .. .	..	..	2	10	15
Malaria Supervisors .. .. .	..	..	5		
Mistry .. .. .	..	..	1		
Field workers .. .. .	..	..	25		

*List of equipment required for the Provincial Headquarters Unit.*

- |  |         |  |
|--|---------|--|
| 1. Microscopes, high power   | .. .. . | Ten.   |
| 2. Microscopes, dissecting, small  | .. .. . | Ten.   |
| 3. Microscopes, dissecting, binocular  | .. .. . | Two.   |
| 4. Other laboratory equipment of the type of hand lenses, breeding cages, glassware, balance, primus stoves, etc., including chemicals | .. .. . | As required (A yearly allotment of Rs. 800). |
| 5. Surveyor's equipment for the sanitary Engineer and his staff  |         |  |
| 6. Bicycles  | .. .. . | Ten.   |
| 7. Typewriters, standard   | .. .. . | Two.   |
| 8. Typewriters, portable   | .. .. . | One.   |
| 9. Epidiascope for instructional purposes  | .. .. . | One.   |
| 10. Cinema Projector instructional purposes  | .. .. . | One.   |

*List of equipment required for the Provincial control Unit.*

(a) Transport—

- |  |         |      |
|--|---------|------|
| (1) Trucks, 3/4 ton 4 × 4, weapons carrier | .. .. . | Two. |
| (2) Trucks, 3/4 ton, 4 × 4 (Jeep)          | .. .. . | One. |

(b) Tentage—

- |                  |         |        |
|------------------|---------|--------|
| Tents, 160 pound | .. .. . | Three. |
|------------------|---------|--------|

(c) Sprayers, spraying equipment, etc.—

- |   |         |              |
|---|---------|--------------|
| (1) Petrol driven sprayers, 1 to 2 H. P.                                      | .. .. . | Four.        |
| (2) MISH type hand sprayers   | .. .. . | One hundred. |
| (3) Knapsack sprayers, oil  | .. .. . | Twelve.      |
| (4) Stirrup pumps, double barrel, complete with special nozzles, lances, etc. | .. .. . | Twenty.      |
| (5) Empty drums, 40 gallons   | .. .. . | Five.        |
| (6) Empty drums, 5 gallons  | .. .. . | Twenty.      |
| (7) Empty drums, 1 gallon   | .. .. . | Twenty.      |
| (8) Buckets, 3-4 gallons  | .. .. . | Forty.       |

(d) Field Worker's Implements—

- |                        |         |            |
|------------------------|---------|------------|
| (1) Hoes               | .. .. . | Two dozen. |
| (2) Pick axes          | .. .. . | One dozen. |
| (3) Machetes           | .. .. . | Two dozen. |
| (4) Axes, wood cutting | .. .. . | Six.       |

(e) Laboratory equipment such as hand lenses, breeding cages, catching apparatus, glassware, balance, primus stoves, etc.

As required (A yearly allotment of Rs. 3,000/-)

- |                         |         |      |
|-------------------------|---------|------|
| (f) Portable typewriter | .. .. . | One. |
|-------------------------|---------|------|

## APPENDIX 15.

## MODEL MOSQUITO ORDINANCE.

*United States Public Health Service.*

*Section 1.*—It shall be unlawful for any person to have, keep, maintain, cause, or permit within the corporate limits of . . . . . any collection of standing or flowing water in which mosquitoes breed or are likely to breed, unless such collection of water is treated so as effectually to prevent such breeding.

*Section 2.*—Collections of water in which mosquitoes breed or are likely to breed are those contained in ditches, ponds, pools, excavations, holes, depressions, open cess-pools, privy vaults, fountains, cisterns, tanks, shallow wells, barrels, troughs (except horse troughs in frequent use), urns, cans, boxes, bottles, tubs, buckets, defective house roof gutters, tanks or flush closets, or other water containers.

*Section 3.*—The natural presence of mosquito larvae in standing or running water shall be evidence that mosquitoes are breeding there.

*Section 4.*—Collections of water in which mosquitoes breed or are likely to breed shall be treated by such one or more of the following methods as shall be approved by the health officer :—

(Here follows description of methods).

*Section 5.*—In case the person responsible for the condition of premises on which mosquitoes breed or are likely to breed, fails or refuses to take necessary measures to prevent their breeding within three days after notice in writing has been given him by the health officers, or within such longer time after such notice as may be specified in the notice, the said person responsible shall be deemed guilty of a violation of this ordinance ; and for each day after the expiration of three days from the day on which such notice is given him, or for each day after the expiration of the time specified in the notice, as the case may be, that the person responsible fails or refuses to take such measures, the said person responsible shall be deemed guilty of a separate violation of this ordinance, and in case of such failure or refusal of the person responsible, the health officer is authorised to take necessary measures to prevent the breeding of mosquitoes, and all necessary costs incurred by the health officer for that purpose shall be a charge against the person responsible.

*Section 6.*—For the purpose of this ordinance the person responsible for the condition of any premises is the person using or occupying the same ; or, in case no person is using or occupying the premises, the person who by law is entitled to the immediate possession of the same ; or in case the premises are used or occupied by two or more tenants of a common landlord ; each tenant, however, is responsible for that part of the premises, which he occupies to the exclusion of the other tenants ; provided, that in case the premises are occupied by a tenant under an yearly or monthly tenancy, or under a lease for not more than a year, or under any lease whereby the lessor is expressly or impliedly obligated to keep the premises in repair, and the collection of standing or flowing water in which mosquitoes breed or are likely to breed is owing to the disrepair of the building or buildings, or to any natural quality of the premises, or to any conditions that existed at the time when the tenant entered into possession, or to anything done on the

premises by the landlord during the existence of the tenancy or lease, then and in such case, the landlord is the person responsible ; *provided further*, that any person who has caused to exist on any premises of which he is not the owner, landlord, occupant, or tenant any collection of water in which mosquitoes breed or are likely to breed is responsible, as well as the owner, landlord, tenant, or occupant, as the case may be.

*Section 7.*—For the purpose of enforcing the provisions of this ordinance the health officer, or his lawful subordinate, may at all reasonable times enter in and upon any premises within his jurisdiction.

*Section 8.*—Any person found guilty of a violation of this ordinance, as described in Section 5 hereof, shall be punished by a fine of not less than one dollar (\$ 1) and not more than twenty-five dollars (\$ 25).

*Section 9.*—This ordinance shall be in full force and effect on and after the (.....) day from the day on which it is approved.



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## APPENDIX 16.

## DESTRUCTION OF MOSQUITOES.

*Straits Settlements.*

## Ordinance No. 174.

To provide for the destruction of mosquitoes :—

1. *Short title. Application.*—This Ordinance shall apply to all property of every description including that belonging to or vested in or maintained by the Crown.

2. *Interpretation.*—In this Ordinance, unless there is something repugnant in the subject or context,

“ House ” .. includes dwelling house, warehouse, office, shop, school and any other building in which persons are employed ;

“ Mosquito ” .. means the insect and includes its eggs, larvae and pupae ;

“ Owner ” .. includes the person for the time being receiving the rent of any premises, whether on his own account or as agent or trustee or as receiver, or who would receive the same if such land or house were let to a tenant, and includes the Crown ;

“ Occupier ” .. means the person in occupation of any premises or having the charge, management or control thereof either on his own account or as agent of another person but does not include a lodger ;

“ Premises ” .. includes messuages, buildings, lands, easements and hereditaments of any tenure, whether open or enclosed, whether built on or not, whether public private, and whether maintained or not under statutory authority ;

“ Sanitary Authority ” .. means within any Municipal limits, the Municipal Health Officer and in any Rural District, the Rural Board Health Officer.

3. *Entry and inspection by sanitary authority or authorized person.*—(1) The sanitary authority or any person authorised by him either generally or specially in that behalf in writing may, between the hours of six in the morning and six in the evening, with or without assistants, enter and examine any premises in order to ascertain whether they or any thing thereon are in a condition favourable to the propagation or harbouring of mosquitoes ; provided that no person shall, unless with the consent of the occupier, thereof, enter any house under this section without twelve hours' previous notice being given to the occupier, if any, thereof.

(2) Subject to such notice as aforesaid, the owner and the occupier of any premises shall permit the sanitary authority or any person so authorised by him as aforesaid with or without assistants to have access thereto and to any part thereof for the purpose of subsection (1) and shall supply all such information as the sanitary authority requires and as is reasonably necessary for that purpose.

**4. General power of sanitary authority to order action.**—(1) The sanitary authority, if as a result of any such examination it appears to him that any premises or anything thereon is favourable to the propagation or harbouring of mosquitoes, may, by order in writing addressed to the owner or occupier of such premises direct him within a specified time to take such specified measures with regard to the premises or for the treatment, destruction or removal of anything thereon as may bring them into a condition not favourable to the propagation or harbouring of mosquitoes.

(2) In particular and without prejudice to the generality of the powers aforesaid the sanitary authority may in such order direct the owner or occupier to drain any land or fill up inequalities in the surface thereof so as to keep the land permanently free from standing water to the extent required by the order.

**5. Power of sanitary authority to order covering of tanks, etc.**—(1) The sanitary authority may, by order in writing, direct the occupier of any premises so to cover within a specified time and keep continuously covered any specified vessel or receptacle, including any tank or cistern, on or appertaining to the premises that mosquitoes shall be unable to enter such vessel or receptacle.

(2) Where any premises are unoccupied such order may be addressed to the owner thereof as if he was the occupier.

**6. Power of sanitary authority to take preventive measures.**—The sanitary authority or any person authorised by him, either generally or specially in that behalf in writing may also, with the consent of the occupier, take such measures as are reasonably necessary.—

- (a) to destroy mosquitoes wherever found ;
- (b) to collect and remove empty tins, cans, bottles or other receptacles in which mosquitoes may breed ;
- (c) to cut down and remove any grass, bamboo stumps, fern or undergrowth in which mosquitoes are likely to breed or be harboured ;
- (d) to bring any water or swamp into a condition not favourable to the propagation or harbouring of mosquitoes ;
- (e) to fill with concrete or otherwise treat holes or hollows in trees which hold or are likely to hold water.

**7. Enforcement of order.**—(1) If the owner or occupier of any premises on whom an order under section 4 or 5 has been served fails to comply with the terms thereof, the sanitary authority or any person authorised by him, either generally or specially in that behalf in writing may enter upon or into the said premises with such assistants and things as are necessary and may perform and do thereon or therein all acts and things required by the said order to be performed or done, and the cost thereof shall be recoverable from the owner or occupier by the sanitary authority.

(2) If the amount of such costs is not paid by the party liable to pay the same within seven days after demand, such amount may be reported to a Police Court and recovered in the same way as if it was a fine imposed by such Court.

(3) Nothing in this section shall affect any liability of any person to prosecution and punishment under section 8.

8. *Penalty for default.*—(1) Any owner or occupier of any premises, on whom an order under section 4 or 5 has been served, who neglects to comply with the terms thereof, shall be liable, on conviction by a Police Court, to a fine not exceeding five hundred dollars or to imprisonment of either description for a term which may extend to six months.

(2) No person shall be punishable under this section for neglect to comply with any order in respect whereof he has appealed as hereinafter provided unless such order has been confirmed on appeal.

10. *Persons unable to meet necessary expenditure.*—If it appears to the sanitary authority after due inquiry that any person has not the means to meet the necessary expenses of doing anything required to be done by him under this Ordinance, such necessary expenses may be met from Municipal or Rural Board Funds, as the case may be.

11. *No compensation.*—No person shall be entitled to compensation for any expense incurred or damage occasioned by any order given or act done in pursuance of this Ordinance or any rule made thereunder unless such damage has been occasioned maliciously or without reasonable cause.

13. *Penalty for obstructing sanitary authority.*—Any person, who obstructs the sanitary authority or any person authorised by him or any person engaged in carrying out this Ordinance in any act authorised by this Ordinance, shall be liable, on conviction by a Police Court, to a fine not exceeding two hundred dollars or to imprisonment of either description for a term which may extend to three months.

14. *Penalty for injuring works, etc., executed, etc., by sanitary authority.*—Any person who, without the consent of the sanitary authority, interferes with, injures, destroys or renders useless any works executed or any materials or things placed in, under or upon any premises by or under the orders of the sanitary authority, shall be liable, on conviction before a Police Court, to a fine not exceeding five hundred dollars, and the sanitary authority may in addition recover from such person in the same manner as if it was a fine imposed by a Police Court, such costs and expenses as it incurs in re-executing the works or replacing the materials or things so interfered with, injured, destroyed or rendered useless.

15. *Duty of owner and occupier to protect works for destruction of mosquitoes.*—(1) Where the sanitary authority or any department of Government or the Municipality has constructed any works with the object of preventing the breeding of mosquitoes whether before or after the coming into force of this Ordinance the owner and the occupier of the premises on which such works stand shall prevent such premises being used in any manner whatsoever that is likely to cause or has caused the deterioration or to lessen the efficiency of such works.

(2) *Penalty.*—Where any such premises are used in such a manner as to lessen the full efficiency of such works the owner and the occupier of such premises shall subject to sub-section (4) be liable on conviction before a Police Court to a fine not exceeding five hundred dollars and the sanitary authority may enter upon the premises and execute any necessary repairs or work thereon and recover from such person in the same manner as if it was a fine imposed by a Police Court such costs and expenses as it thereby incurs.

## APPENDIX 17.

## ANTIMOSQUITO PROVISION IN THE BOMBAY MUNICIPAL ACT.

*Section 3.—Definition of terms :—*

(t) "*Water work*" includes a lake, stream, spring, pump, reservoir, cisterns, tank, duct, whether covered or open, sluice, mainpipe culvert, engine and any machinery, land, building or thing for supply or used for supplying water.

(z) "*Nuisance*" includes any act, omission, place or thing which causes or is likely to cause injury, danger, annoyance or offence to the sense of sight, smelling or hearing, or which is or may be dangerous to life or injurious to health or property.

(aa) "*Dangerous Disease*" means cholera and any endemic, epidemic or infectious disease by which the life of man is endangered.

*Section 61.—Matters to be provided for by the Corporation.*—It shall be incumbent on the corporation to make adequate provision, by any means of measures which is lawfully competent to them to use or take, for each of the following matters, namely :

(d) The reclamation of unhealthy localities, the removal of noxious vegetation and generally the abatement of all nuisances.

(g) Measures for preventing and checking the spread of dangerous diseases.

*Section 64.—Special functions of the Commissioner.*—(3) subject, whenever it is in this Act expressly so directed, to the approval or sanction of the corporation or the standing committee and subject also to all other restrictions, limitations and conditions imposed by this Act, the entire executive power for the purpose of carrying out the provisions of this Act vests in the Commissioner.

*Section 68.—Municipal officers may be empowered to exercise certain of the powers of the Commissioner.*—(1) Any of the powers, duties or functions conferred or imposed upon or vested in the Commissioner by any of the sections, sub-sections, or clauses mentioned in sub-section (2) may be exercised, performed or discharged, under the Commissioner's control and subject to his revision and to such conditions and limitations, if any, as he shall think fit to prescribe, by any municipal officer whom the Commissioner, generally or specially empowers in writing in this behalf; and in each of the said sections, sub-sections and clauses the word "*Commissioner*" shall, to the extent to which any municipal officer is so empowered, be deemed to include such officer.

(2) The sections, sub-sections and clauses of this Act referred to in sub-section (1) are the following namely :—

279, 374, 377, 381, 381A, 488, 489.

*Section 274.—Provisions as to cisterns.*—(1) The Commissioner may whenever it shall appear to him to be necessary, by written notice require, that any premises furnished with a private water-supply from any municipal water-work shall, within a reasonable period, which shall be prescribed in the said notice, be provided with a storage cistern of such size, material, quality and description, and with such fittings and placed in such a position and with such means of access as he thinks fit.

*Section 279.—Power to cut off private water-supply or to turn off water.*—(1) The Commissioner may cut off the connection between any municipal water-work and any premises to which a private water-supply is furnished by the corporation or turn off the water from such premises in any of the following cases, namely :—

(b) if the owner or occupier of the premises neglects, within the period prescribed in this behalf in any notice given under sub-section (1) of section 274, to comply with any requisition made to him by the Commissioner regarding the provision of a storage-cistern, or the means of access thereto, provided that.....the Commissioner shall not take action without the sanction of the standing committee.

*Section 374.—Power to inspect premises for sanitary purposes.*—The Commissioner may inspect any building or other premises for the purpose of ascertaining the sanitary conditions thereof. (But see Section 488).

*Section 377.—Neglected premises.*—If it shall appear to the Commissioner that any premises are overgrown with rank and noisome vegetation or are otherwise in an unwholesome or filthy condition, or, by reason of their not being properly enclosed are resorted to by the public for purposes of nature, or are otherwise a nuisance to the neighbouring inhabitants, the Commissioner may, by written notice, require the owner or occupier of such premises to cleanse, clear or enclose the same, or, with the approval of the standing committee, may require him to take such other order with the same as the Commissioner thinks necessary.

*Section 381.—Filling in of pools, etc., which are a nuisance.*—(i) If in the opinion of the Commissioner—

(a) any pool, ditch, tank, well, pond, quarry-hole, drain, watercourse or any collection of water, or

(b) any cistern, receptacle for water or any article or thing capable of containing water whether or not such cistern or receptacle, article or thing contains water and is within or outside a building, or

(c) any land on which water accumulates or is likely to accumulate, or

(d) any premises or part of any premises occupied or unoccupied, or under construction, reconstruction or demolition, is or is likely to become a breeding place of mosquitoes or which is in other respects, a nuisance as defined in clause (z) of section 3.

(ii) The Commissioner may by notice in writing require the person by whose act, default or sufferance, a nuisance arises, exists or continues, or is likely to arise, and the owner, lessee or occupier of the land, building or premises on which the nuisance arises, exists or continues or is likely to arise, or any one or more of such person, owner, lessee and occupier, to remove, discontinue or abate the nuisance by taking such measures and by executing such work in such manner with such materials as the Commissioner shall prescribe in such notice.

(iii) The Commissioner may also by any notice under clause (ii), or by another notice, served on such person, owner, lessee and occupier, or on any one or more of them require them or any one or more of them to take all steps requisite or necessary to prevent a recurrence of the nuisance, and may, if he thinks it desirable, specify any work to be executed or measures to be carried

out for that purpose, and may serve any further such notice notwithstanding that the nuisance may have been abated or removed, if he considers that it is likely to recur.

Provided that if at any time within six months from the date of the service of any such notice, the nuisance recurs through the failure of the person or persons upon whom such notice has been served to comply with the requirements contained in such notice, such person or persons shall be liable without any further notice to the penalties provided in this Act for offences under this section.

(iv) Where the nuisance arises or exists or is likely to arise or recur in connection with the construction, reconstruction or demolition of any premises, or part of any premises, the Commissioner may in addition to serving any notice on any one or more of the persons mentioned in clause (ii) serve any such notice on any architect, contractor or other person employed to carry out such work of construction, reconstruction or demolition, and also on any sub-contractor employed by such contractor or other person, or any one or more of such contractor, person and sub-contractor.

*Section 381A.—Permission for new well, etc.*—(1) No new well, tank, pond, cistern or fountain shall be dug or constructed without the previous permission in writing of the Commissioner.

(2) If any such work is begun or completed without such permission, the Commissioner may either—

(a) by written notice require the owner or other person who has done such work to fill up or demolish such work in such manner as the Commissioner shall prescribe, or

(b) grant written permission to retain such work, but such permission shall not exempt such owner from proceedings for contravening the provisions of sub-section (1).

*Section 461.—By-laws, for what purposes to be made.*—The corporation may from time to time make by-laws, not inconsistent with this Act, with respect to the following matters, namely :—

(a) regulating, in any particular not specifically provided for in this Act, the construction, maintenance and control of drains, ventilation-shafts or pipes, cess-pools, water-closets, privies, latrines, urinals, drainage-works of every description, whether belonging to the corporation or to other persons; municipal water-works, private communication-pipes and public streets;

(b) regulating all matters and things connected with the supply and use of water.

*Section 471.—Certain offences punishable with fine.*—whoever

(a) contravenes any provision of any of the sections, sub-sections or clauses mentioned in the first column of the following table, or of any regulation made thereunder; or

(b) fails to comply with any requisition lawfully made upon him under any of the said sections, sub-sections or clauses ;  
shall be punished, for each such offence, with fine which may extend to the amount mentioned in that behalf in the third column of the said table.

Section, sub-section or clause.	Subject.	Fine which may be imposed.
Section 274 ..	Requisition to provide storage cisterns and other fittings to be used for connections with water works.	Rs. 50
Section 377 ..	Requisition to cleanse, etc., neglected premises	50
Section 381 ..	Requisition to fill in pools, etc., which are a nuisance.	50
Section 381 A, sub-section (1).	Digging or constructing well, etc., without permission.	500
Section 381 A sub-section (2).	Requisition to fill in or demolish well, etc. ..	500

*Section 472.—Continuing offences.*—Whoever, after having been convicted of—

(a) contravening any provision of any of the sections, sub-sections or clauses mentioned in the first column of the following table, or of any regulation made, thereunder, or

(b) failing to comply with any requisition lawfully made upon him under any of the said sections, sub-sections or clauses,  
continues to contravene the said provision or to neglect to comply with the said requisition, or fails to remove or rectify any work or thing done in contravention of the said provision, as the case may be, shall be punished for each day that he continues so to offend, with fine which may extend to the amount mentioned in that behalf in the third column of the said table.

Section, sub-section or clause.	Subject.	Daily Fine which may be imposed.
Section 377 .. ..	Regulation to cleanse, etc., neglected premises	Rs. 5
Section 381 .. ..	Requisition to fill in pools, etc., which are a nuisance.	50
Section 381 A, sub-section (2).	Requisition to fill in or demolish well, etc. ..	50

*Section 488.—Power of entry.*—The Commissioner may enter into or upon any building or land, with or without assistance or workmen, in order to make any inspection or survey or to execute any work which is authorised by this Act or by any regulation or by-law framed under this Act to be made or executed, or which it is necessary for any of the purposes, or in pursuance of any of the provisions, of this Act or of any such regulation or by-law, to make or execute.

Provided that—

(a) except when it is in this Act otherwise expressly provided, no such entry shall be made between sunset and sunrise ;

(b) except when it is in this Act otherwise expressly provided, no building which is used as a human dwelling shall be so entered, unless with the consent of the occupier thereof, without giving the said occupier not less than twenty-four hours' previous written notice of the intention to make such entry, and unless for any sufficient reason it shall be deemed inexpedient to furnish such information, of the purpose thereof;

(c) sufficient notice shall in every instance be given, even when any premises may otherwise be entered without notice, to enable the inmates of any apartment appropriated to females to remove to some part of the premises where their privacy need not be disturbed ;

(d) due regard shall always be had, so far as may be compatible with the exigencies of the purpose for which the entry is made, to the social and religious usages of the occupants of the premises entered.

*Section 489.—Enforcement of orders to execute works, etc.*—(1) When any requisition or order is made, by written notice, by the Commissioner or by any municipal officer empowered under section 68 in this behalf, under any section, sub-section or clause of this Act mentioned in sub-section (2), a reasonable period shall be prescribed in such notice for carrying such requisition or order into effect and if, within the period so prescribed, such requisition or order or any portion of such requisition or order is not complied with, the Commissioner may take such measures or cause such work to be executed or such thing to be done as shall, in his opinion, be necessary for giving due effect to the requisition or order so made, and, unless it is otherwise in this Act expressly provided, the expenses thereof shall be paid by the person or by any one of the persons to whom such requisition or order was addressed.

(2) The sections, sub-sections and clauses of this Act referred to in sub-section (1) are the following, namely :—

274, 377, 381, 381A.

(3) The Commissioner may take any measure, execute any work or cause anything to be done under this section, whether or not the person who has failed to comply with the requisition or order is liable to punishment or has been prosecuted or sentenced to any punishment for such failure.

*Section 517.—Legal proceedings.*—(1) The Commissioner may—

(a) take, or withdraw from, proceedings against any person who is charged with—

(i) any offence against this Act ;

(ii) any offence which affects or is likely to affect any property or interest of the corporation or the due administration of this Act ;

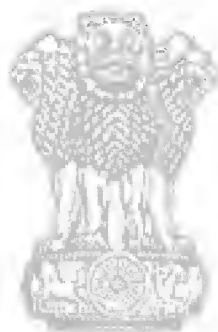
(iii) committing any nuisance whatsoever.

*Section 518.—Power to Government to provide for performance of duties in default of any municipal authority.* (1) If, upon complaint being made to him and after such inquiry as he thinks fit to make, it shall at any time appear, to the Governor in Council that any of the provisions of sections 61, 381 and 381A, . . . . . have not been or are not being duly carried out or enforced, the Governor in Council may make an order prescribing a period within which such provision shall be carried out or enforced.



(2) Provided, that, except in any case which appears to the Governor in Council to be one of emergency, no such order shall be made until after the expiry of one month from the date of service of a written notice on the corporation, and, if the Governor in Council shall think fit, on the Commissioner, requiring cause to be shown why such order should not be made, nor until the cause, if any, so shown has been considered by the Governor in Council.

(3) If, within the period prescribed in an order made under sub-section (1) the provision is not carried out or enforced, the Governor in Council may appoint some person to carry out or enforce the same and may direct that the expense of carrying out or enforcing such provision together with such reasonable remuneration to the person carrying out or enforcing the same as the Governor in Council shall determine, and the cost of the proceedings under this section shall be paid out of the municipal fund.



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## APPENDIX 18.

EXTRACTS FROM THE ANNUAL REPORT OF THE PUBLIC HEALTH  
COMMISSIONER WITH THE GOVERNMENT OF INDIA FOR 1936.(1) *The Leprosy Colony at Uzuakoli in Africa.*

During 1936-37 the colony had a total population of 1,061 inhabitants, of whom 901 were resident patients on 31st March, 1937. A few years previously the site of the colony was a dense jungle, but Dr. Brown, the first Medical Superintendent, who built up the institution, worked with enthusiasm, patience and tact and since August, 1932, when the first patients were admitted, the colony has grown into a community of lepers, who carry out among themselves all the functions of civilized life including agriculture, industry, housing, education of the children, social activities and even maintenance of law. All patients are expected to work. Every able-bodied patient receives on admission a farm and a certain quantity of seed; at harvest time he has to return a portion to the community store. Various local agricultural products are produced. The palm oil industry is a flourishing concern, whilst other industries include weaving, carving, tailoring, net making, manufacture of musical instruments, basket making and soap manufacture. The cultivation of *Hydnocarpus wightiana* is also being attempted. Road making and house-building are important occupations and blacksmiths and carpenters thrive. All of the 170 children in the colony attend the school which is staffed by eight teachers, some of whom had teaching experience before they joined the colony.

As the outside population have a prejudice against buying articles made by lepers, these are sold by the patients to their fellow patients, so that internal consumption forms the main incentive for industrial activity.

Exercise for the patients is by no means neglected. For many, their occupations afford sufficient exercise in the open air; for those who work indoors, like teachers and nurses, football, volley ball and tennis provide recreation and exercise.

The most admirable part of the community life is the excellent discipline and spirit of harmony that prevail among the inmates although about 300 villages are represented in the colony. All offences are tried by a court consisting of the Chief assisted by a council of headmen and a head woman and although all have a right of appeal to a special court conducted by the medical officer, its jurisdiction is seldom necessary.

Seventeen babies have been born in the colony to leper mothers. These infants were all separated from their mothers at birth and were admitted to a Babies house, where they were brought up on artificial foods, exception being made in the case of small and feeble infants, which were permitted to be breast-fed by the mothers, care being taken to prevent contact with the mother except at the nipple.

All patients received treatment on modern lines and during the year 17 persons were discharged as cured because of "absence of symptoms, return of pigmentation and sensation in the patches, and repeated negative bacteriological examinations."

The whole institution is managed on an economical basis and running costs amount to the incredibly small sum of about Rs. 3-8-0 per patient per month, this including the staff comprised of a Medical Superintendent, a T.H. worker who looks after the industrial and agricultural side of the work,

lady honorary worker, who attends to the unaffected children and the nursing staff. This is a surprisingly fine achievement and it has been rendered possible only because of the spirit of self-sacrifice that the founder brought to task he had assumed, his genius for organisation and an understanding sympathy which enabled him to win the confidence of the African and enlist his co-operation for his own betterment.

(2) *Forest Farm Colony at Mangaltarai in the Central Provinces.*

This is a co-operative undertaking, Government, the American Mennonite Mission and the Mission to Lepers all being represented on the Board of Control :—

“ Its primary purpose is to re-establish in life arrested cases of the disease who have cleared up in Mission Homes in the Central Provinces and Berar, but who need to live under healthy conditions and with some assurance of a livelihood if the risk of relapse is to be reduced to a minimum. It is also for healthy children of lepers, that they too may have opportunity of winning from the forest their own farmstead. ”

An area of 6,288 acres was set aside by the Government for the purpose of providing holdings of 15 acres each and the terms of the settlement provide that, for the first two years, 20 per cent. of the persons admitted might be non-leprous people with agricultural experience in order to help the regular colonists to settle down to an agricultural life. The Government provided funds for water supply and for clearing the land, whilst the Mission to Lepers sanctioned a grant to help the colonists to tide over the first few months until the harvesting of the first crops. The American Mennonite Mission sanctioned the appointment of one of its members as the manager of the colony and he busied himself with organising the work, establishing a rural school, introducing a medical service, supervising a co-operative society and dealing with the many other problems of a pioneer venture. The development of this undertaking will be watched with interest ; its success will no doubt encourage others to make similar attempts to relieve the leprosy situation of the country.

The great importance of protecting children from infection has already been emphasised and, under existing conditions, it is almost impossible to prevent spread of infection to this susceptible group of the community. The development of leper colonies should be able to play a prominent part in this direction. In the first place, provision can be made for the segregation of infants born to leprous mothers ; secondly, life in the colony is itself an education to the resident patient in that he learns to avoid infecting others ; and, lastly, when he is discharged, he can help to spread the knowledge he has gained amongst his friends and acquaintances.

## APPENDIX 19.

**EXTRACT FROM THE REPORT ON LEPROSY AND ITS CONTROL IN INDIA (1941)  
BY A SPECIAL COMMITTEE APPOINTED BY THE CENTRAL ADVISORY BOARD OF  
HEALTH.**

Certain principles recommended by this Committee for regulating future leprosy legislation.

(1) The disease should be notifiable but notification should be confidential and confined to cases who are infective. The present legislation for the notification of leprosy is to a large extent a dead letter.

(2) Legislation should provide power to isolate infective cases which are a danger to the community. For paupers who are suffering from leprosy, however, as defined in Section 2 of the present Lepers Act, legal power should apply to all cases.

(3) A patient compulsorily isolated outside his own home should be maintained at public expense.

(4) When a pauper suffering from leprosy is removed to an asylum under legal powers the complete cost of his maintenance in the asylum should be met by the administrative authority applying the Act.

(5) Legislation should include powers for the Health Officers to examine cases who are suspected to be in an infective condition.

(6) Legal powers regarding the occupation of patients with leprosy detailed in the present Lepers Act, shall be retained but for infective cases only.

(7) The powers of arrest and removal of a person who appears to be a pauper suffering from leprosy should be entrusted to the health authorities and the services of the Police called in only when difficulty arises.

(8) Legal power should be provided whereby a person who, after commitment to an asylum, absconds, can be committed to a Leper Jail by order of a magistrate. Section 12 of the Lepers Act provides for arrest without warrant and return to the asylum of persons compulsorily isolated. This is inadequate.

# APPENDIX 20.

## *Centres where facilities for radium and deep X-ray treatments are provided.*

Province.	Whether facilities for radium treatment exist. If so, in which hospital.		Remarks.	Whether deep X-ray therapy is provided. If so, in which hospital.	Remarks.
1 Delhi	..	Yes. At Lady Hardinge Hos- pital.	..	No.	..
2 U. P.	..	..	..	Yes. At the Medical College, Agra, and King George's Medical College, Lucknow.	Two more deep X-ray therapy units are proposed to be installed in the Province under postwar reconstruction scheme (Gorakhpur & Benares).
3 Bihar	..	Yes. At Patna Medical Col- lege Hospital.	..	Yes. At Patna Medical Col- lege Hospital.	..
4 C. P. & Berar	..	No	..	No.	It is proposed to provide deep X-ray therapy when the New Mayo Hospital, Nagpur, is built in the five-year postwar plan.
5 Ajmer	..	No	..	No.	..
6 Coorg	..	No	..	No.	..
7 Madras	..	Yes. At Barnard Institute of Radiology, Government General Hospital, Madras, & King George Hospital, Vizagapatam.	..	Yes. At Barnard Institute of Radiology, Government General Hospital, Madras and Erskine Hospital, Madras.	..
8 N. V. F. P.	No	..	..	No.	Arrangements are being made to provide deep-X-ray therapy in the Lady Reading Hospital, Peshawar.



## APPENDIX 21.

REPORT BY COLONEL M. TAYLOR, O.B.E., M.D., D.P.H., I.M.S., ON HIS TOUR OF MENTAL HOSPITALS AT THE REQUEST OF THE HEALTH SURVEY AND DEVELOPMENT COMMITTEE.

## CALCUTTA.

I commenced my tour on 30th December, 1944, in order to meet Dr. G. Bose, in Calcutta, as he intended leaving the city on 1st January, 1945, for some weeks.

In Calcutta, I visited and inspected the following :—

- (1) Lumbini Park Mental Hospital and Clinic.
- (2) The Mental Hospital for Male Patients at Mankundu.
- (3) The Mental Hospital for Females, 78, Lower Circular Road, Calcutta.
- (4) The Observation Ward, Bhawanipore.
- (5) The Out-door Neuro-Psychiatric Clinic, Medical College Hospital, Calcutta.
- (6) The Out-door Neuro-Psychiatric Clinic, Carmichael Medical College, Calcutta.

## Lumbini Park Mental Hospital.

This institution is managed by the Indian Psycho-Analytical Society. The daily average number of in-patients treated is 20 (males 14, females 6). During the period 5th February, 1940, to 31st December, 1941, a total of 175 new mental cases attended the Outdoor Clinic.

The Outdoor Clinic at Lumbini Park Mental Hospital is also open to General Patients (8,191 was the total number attending from day to day during the period 5th February 1940—31st December 1941).

There are two Resident Physicians, the respective salaries being Rs. 100/- and Rs. 75/- per mensem, and a number of honorary visiting physicians who attend for a total of 14 hours per week. The work of the outdoor clinic and routine work can leave very little time at the disposal of the resident physicians for ward work, and the salaries paid to the Nursing Personnel would indicate that the nursing care cannot be of a very high standard.

The Senior Nurse receives a salary of Rs. 20, and the three remaining members of the Nursing Staff receive salaries at the rate of Rs. 15 per mensem, plus food and lodging. Sixteen male attendants receive salaries at Rs. 25, and five female attendants Rs. 10, plus food and lodging.

It is stated in the report from 5th February 1940 to 1st December 1941 that "for want of funds trained nurses cannot be employed to look after the patients".

The rates for indoor patients are as follows :—

	Rs.
(i) First Class Bed .. .. .	300 p.m.
(ii) Second Class Bed .. .. .	200 p.m.
(iii) Third Class Bed .. .. .	150 p.m.

and "a special charge shall be made if special nursing has to be arranged for; this shall only be done with the written sanction of the guardians; the charge for the special nurse shall be paid in advance. Special medicines will also be charged for at cost price".

The rates at the European Mental Hospital, Ranchi are as follows.—

	Rs.
(i) First Class (inclusive of three private attendants)	300 p.m.
(ii) Second Class (inclusive of two private attendants)	200 p.m.
(iii) Third Class	46 p.m.

with European diet, all drugs, and no charge for extras.

\* In (i) and (ii) the guardians are called upon to meet the cost of "Dearness Allowance" to the private attendants at the scale as sanctioned by Government.

It is obvious that (apart from the one free bed) Lumbini Park Mental Hospital cannot, at present, be widely patronised by the general community.

Owing to the small numbers the *per capita* rate is extremely high—viz., Rs. 2,091 per annum.

It has been pointed out that the visiting physicians who are all highly qualified, spend a total of 14 hours per week in the hospital. This can scarcely be considered adequate for specialized treatment. One of the honorary physicians is a M.R.C.P.E., D.P.M., but he visits one day per week for two hours. Honorary Physicians are, as a rule, very jealous of their prerogative but take their responsibilities lightly.

The equipment is neither extensive, nor modern, and the environment of the hospital leaves much to be desired. There is little provision for diversion, occupational therapy, or rehabilitation.

The institution to all intents and purposes is a Private Home, and hampered as it is by its extensive outdoor clinic for general patients, and lack of funds, it cannot be considered a satisfactory institution for the treatment of mental patients. As at present conducted, I do not rate the facilities for training very highly. This institution, given adequate funds to meet the cost of expansion on modern lines, would, in time, become both a useful hospital, and a good teaching school.

#### **Mankundu Mental Hospital, Calcutta.**

The Male Section of this hospital is situated at Mankundu, about 22 miles from Calcutta City, and the Female Section at 78, Lower Circular Road, Calcutta.

The daily average number of patients in both sections, is 56 (males 43, females 13).

The aims of this institution according to the prospectus are:—

(i) To provide for up-to-date institutional treatment of mental cases, and to place the same within the reach of the middle classes.

(ii) To provide facilities for training in, and research in Psychiatry and Psychological Therapy.

(iii) To train up nurses for attending to mental cases.

The lack of funds has, so far, prevented these aims, and all that can be said for the institution, at present, is that even the standard of custodial care cannot yet be considered satisfactory.

In the male section at Mankundu, the buildings are good, but in a very bad state of repair, and the compound (there is no Mali) is an absolute jungle. I found the patients under poor control, and the whole atmosphere of the hospital was most depressing.



### The Mental Hospital for Females.

The female section (75, Lower Circular Road, Calcutta) is located in a rented house, not very suitable for the purpose, but the patients appeared to be happier and better cared for.

I gained the impression that the Nursing Personnel in both sections was of poor quality and totally inadequate.

Here again, there is an imposing list of Visiting Physicians. Their hours of attendance are not specified, but the state of the institution, as a whole, reflects no credit on any one. It stands as an indictment to Bengal.

The Chief Medical Officer and the Secretary to the Court of Governors of this hospital, who accompanied me on my visit, are well aware of the limitations of this Institution, as is the Court of Governors. The Court has appealed to Government for financial aid, and they have offered to hand the institution over to the control of Government. If financial aid is not forthcoming the Court envisages the early closure of this hospital. The buildings and land were a gift, but, as is usual with such gifts, carry no endowment.

The Court of Governors in 1941 appointed a sub-committee to enquire into the management of this hospital. The following are some extracts from the report of the sub-committee:—

“While paying our highest compliments to the Founder Secretary for his bold and single-handed efforts, we cannot but state that the hospital has, so far, been working with thoroughly inadequate equipment”.

“It seems that the authorities of the hospital had no idea of the eminence which this institution was destined to rise to in so short a time. Considering the difficulties of managing mental patients in private homes and the hardship entailed in securing accommodation in the Ranchi Hospital (Indian) where the accommodation is scarcely sufficient for Criminal Lunatics\*, it is no wonder that the first non-official attempt in this line was kindly received, leniently judged, and eagerly availed of by the public. We hold, however, that the hospital should be properly equipped without further delay.”

I endorse the comments of this sub-committee with regard to the Founder-Secretary, whom I had the pleasure of meeting, and I would also pay a tribute to the medical men who have attempted the impossible with the meagre resources at their disposal and the numerous handicaps with which they had to contend. The results attained, in spite of the very formidable obstacles, reflect credit on the entire staff. They have, in a small measure, assumed a responsibility which Government and the Corporation have, so far, shirked.

Fifty per cent. of the patients in this hospital are non-paying, and the maintenance charges for paying patients are much less than at Lumbini Park.

The attending physicians receive travelling allowance only, while the remuneration of the nursing staff and attendants is rather less than is normally paid to menials.

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\* The statement in this report, that the accommodation in the Indian Mental Hospital, Ranchi, is scarcely sufficient for criminal lunatics, is incorrect. The total authorised accommodation is for 1,300 patients, and the number of criminal patients at present under treatment is 421 (males 392, females 29).

Until adequate funds are available for vast improvements in the buildings, adequate whole-time qualified personnel, and modern equipment this institution is neither in a position to render modern treatment in the psychoses, nor to afford any facilities for teaching in Psychiatry.

**Mental Observation Ward, Bhawanipore,  
Calcutta.**

This institution receives Magistrates' cases, and patients for observation sent by the police authorities.

The Superintendent is the professor of Medical Jurisprudence in the University, and, *as a side-line*, he is Lecturer in Mental Diseases. The Buildings are first class, in very good order (rather over-done with massive iron bars), and located in a central area of the city. There are 30 beds, and the daily average number of patients is 10.

It is here that the under-graduates receive their instruction in the psychiatry (ten lecture demonstrations), and to augment the clinical material, twelve patients are transported from the Indian Mental Hospital, Ranchi. The patients so transported are classified into three groups:—

Group I. Idiocy (1), Imbecility (1), Obsessional Neurosis (1), G.P.I. (1).

Group II. Mania (2), Melancholia (1), Dementia Paranoides (1).

Group III. Dementia Praecox (Schizophrenia) (1), Paranoia (1), Confusional Insanity (1), Drug Psychosis (1).

The training of the Calcutta Undergraduates in this most important branch of medicine is totally inadequate. The students are merely being exploited. The first essential step would be to divorce Psychiatry from Medical jurisprudence and appoint a Psychiatrist as Lecturer, and the Second, and more important, the provision of suitable clinical material.

I am of the opinion that this institution could be modernised at a small cost and could more efficiently contribute to psychiatric education. I suggested to the Surgeon-General that it would make an admirable Psychiatric Unit, with out-patient department and beds. The Observation Ward would also be possible in the same Unit. The Surgeon-General agreed.

**The Psychological Clinic, Carmichael Medical College, Calcutta.**

This clinic is open from 8 a.m. to 10 a.m. on Tuesdays and Thursdays—Outdoor patients only.

Dr. G. Bose is in charge of the Clinic and is assisted by Dr. Nagendranath De, M.B., D.T.M. (Cal.), M.R.C.P.E., D.P.M. (Lond.), and Dr. S. Banerjee, B.Sc., M.B. (Cal.), D.P.H. (Lond.).

During 1943, 57 new cases from Calcutta and 17 from the mofussil received treatment at this clinic, and 17 old cases from Calcutta and 5 from the mofussil also attended. The total number of patients receiving treatment during 1943, was 96, the average daily attendance was 4 (1 new, 3 old cases), and included Psychoneurotics and Psychotics.

The total expenditure for the year amounted to Rs. 42-2-0.

Clinical lectures and demonstrations were held regularly for senior students of the Carmichael Medical College, and Post-Graduate students of the Department of Psychiatry, University of Calcutta..

**Clinic for Neurology and Psychiatry, Mental College Hospital, Calcutta.**

**PHYSICIAN IN CHARGE**—Dr. Chandra Saha, M.Sc., M.B., D.T.M. (Cal.), F.R.F.P.S. (Glas.), M.R.C.P. (Lond.).

This clinic opened in July 1937, closed in December 1941, re-opened in July 1943, closed again 1943, and again re-opened in March 1944.

As will be seen, this Neuro-Psychiatric clinic has had a chequered career, and in his report of 1942, the Physician-in-charge states "for want of beds and rooms, special methods of treatment and investigation cannot be undertaken".

When this clinic did function, the daily average number of patients was, new cases 1·8, old cases 4, in the proportion of two Psychiatric to one Neurological case.

The Physician-in-charge rightly states that the clinic is still in its embryonic stage, and he has a scheme for further development.

The Principal of the College is against Neuro-Psychiatric Clinics, and considers there should be separate Neurological and Psychiatric Clinics. The consensus of present day opinion is in favour of the Principal's views.

Both clinics are poorly equipped, and conducted entirely by Honorary Physicians, a subject which I shall deal with later.

While in Calcutta I took the opportunity of calling on the Surgeon-General with the Government of Bengal, the Secretary, Public Health and Local Self-Government, Government of Bengal, and the Registrar, Calcutta University. I also made contact with many other gentlemen, including the Professor of Physiology, Medical College, but space is too short to give details of all discussions. They will be embodied in my General Remarks.

I left Calcutta, having formed the opinion that the mental hospitals and clinics which I visited there cannot be considered satisfactory, and are far below the standard which one would expect to find in a University City.

There is a crying need for a modern Mental Hospital for Indians in Calcutta of at least 250 beds—both in the interests of the community and the university. The bulk of the clinical material passes to the Indian Mental Hospital, Ranchi, and it is not feasible either to send large number of patients from Ranchi to Calcutta, or to send Medical Students to Ranchi.

The question of expanding and modernizing the existing Mental Hospitals in Calcutta would be a matter for the Bengal Government; it is advisable that institutions where a teaching programme is carried out should come entirely under Government control and supervision.

It would be more economical, and would lead to greater efficiency, to build in Calcutta a modern Mental Hospital of 250 beds on a suitable site, with a view to possible later expansion to 1,000 beds.

A need which is equally urgent is a Home for Mental Defectives of at least 200 beds.

If the climate in Lahore, Bombay, Agra, Nagpur, Madras, is not considered a bar to the erection of Mental Hospitals, then the project is feasible in Calcutta, and should be seriously considered before further expansion programmes are undertaken at Ranchi.

## MADRAS

**In Madras, my programme included visits to the following :**

- (1) The Government Mental Hospital.
- (2) General Hospital, Madras.
- (3) The Madras University.
- (4) The Madras Medical College.
- (5) The Stanley Medical College.
- (6) Nursery Schools and Montessori Schools.
- (7) The Children's Aid Society.

### The Government Mental Hospital

The hospital is built over a large area (approximately 60 acres), and there is ample ground space and playing fields. The buildings are good and are kept in a good state of repair.

The daily average number of patients during 1943 was 1,223 (males 861, females 362). There are no criminal patients.

The hospital is grossly overcrowded, and only a small percentage of the patients have cots. Some of the best wards are at present requisitioned for A.R.P. work.

In spite of this, the custodial care is of a reasonably good standard (by the term "Custodial Care" I mean the orderly and systematic methods by which physical, recreational, and hygienic activities are regularly carried on).

The Medical Superintendent holds the degree of M.B.B.S. (Madras), and has been on the staff of the hospital for 14 years; the members of the medical staff are temporary, and belong to the General Service cadre, and are not highly qualified.

The Deputy Superintendent who had been on the staff for 2-8/12 years informed me that he was working in the Mental Hospital merely "because he had been posted there", and he sounded as if he had a grievance.

Of the 7 Medical Officers one holds the M.R.C.S., L.R.C.P., and L.M.S.S.A. (Lond.), and six are L.M.Ps. There are two women apothecaries. The Medical Superintendent says he is handicapped by continual changes in the Medical Staff. The Deputy Superintendent with 2-8/12 years service holds the longest record of service of the present staff.

The Medical Superintendent has had no Post-Graduate courses of instruction, and the standard of Psycho-therapy can well be imagined. The Medical Staff is barely sufficient to give proper medical and surgical care to all the patients who develop acute or chronic physical disease during the course of their Psychoses. The ratio per cent discharged recovered to daily average strength is 10.79, and the ratio per cent of cases recovered to direct admissions is only 12.20. These figures indicate that detention rather than therapy is the main function of this institution.

The Medical Superintendent is responsible for the training of Under-Graduates from the Madras, Stanley and Missionary Medical Colleges. There are four courses (12 lectures and demonstrations) per annum; the average number of students attending each course being 35. The number of students receiving instruction is therefore 140 per annum.

I am of the opinion that this responsibility is too heavy for the present Superintendent, who has had no clinical or Post-Graduate experience outside the Madras Mental Hospital. I understand the Madras Government proposes to press for the release of the permanent Superintendent who is at present serving as a Psychiatrist in the Army, and I consider that this is an urgent necessity.

There are no Outdoor Psychiatric Clinics at any of the Madras Hospitals, and this is well, for there are no officers with the qualifications and experience to conduct such clinics.

There are at present no facilities in Madras for Post-Graduate training in Psychiatry. I shall return to this subject in my General Remarks. Let me, however, quote Lt.-Col. G. R. McRobert, I.M.S., Professor of Medicine, Madras, one of the ablest men in the Medical profession in India today, in an address he delivered recently before the Council of Post-Graduate Medical Education of the University of Madras:—

“For diseases of Mind we have not in the whole Madras Presidency, with its teeming millions, and vast amount of mental disorder and Psychoneuroses, a single Mental Expert, technically qualified to teach even up to the pass M.B. standard, far less to instruct Specialists.”

The Social Services which I was invited to visit in Madras are still in the pioneering stage. They included the Children's Aid Society, Egmore; the Madras Vigilance Association, Mylapore; the Nursery School Projects (Vepery Nursery School), and one of the Montessori Schools. They are, no doubt, being conducted conscientiously by persons who are trying to do the job to the best of their ability, but they lack that Psychiatric background which makes for efficiency. There will be no co-ordination in these Social Services until Madras has an organized Mental Health Service. Efficiency is not possible until an adequate number of trained Psychiatrists and Psychologists is available.

I do not believe that Psychiatry is the answer to all problems in life, but there is no doubt that a Psychiatric approach to the understanding of human behaviour should be made to an increasing extent by all workers in the fields of Physiological, Social, and Psychological maladaptation.

### BANGALORE

My programme here included visits to the

- (1) Government Mental Hospital,
- (2) Government Medical Schools,
- (3) Government General Hospitals,

and I had interviews with the Senior Surgeon (the Administrative Medical Officer, Mysore Government), the Residency Surgeon, and some of the Teaching Staff at the General Hospitals.

### Mysore Government Mental Hospital

After the depressing experience at the Mental Hospitals in Calcutta and Madras, it was a real pleasure to visit the Bangalore Mental Hospital. The Hospital is comparatively new (1937), and has been planned on the Villa system, the latest design for Mental Hospitals. The spacious lawns and gardens are well kept.

Accommodation is available for 300 patients (males 200, females 100). The pavilions for male and female patients are self-contained, and arranged in a square quadrangle, with units of 4 to 20 patients. There are single rooms (rather small) in each pavilion, which are intended for boisterous patients.

Special rooms are provided for paying patients, and some Cottages are available for well-to-do patients.

All the essentials for modern treatment are present in this hospital—modern Hydrotherapeutic Units, a well-equipped Operation Theatre, a Psychological Laboratory, conducted by a full-time qualified Psychologist, a useful Occupational Therapy Department, a Club and Diversional Therapy Units, excellent Surgical and Laboratory Equipment, and extensive Fruit and Vegetable Garden, where patients so inclined can occupy themselves.

Electrical Convulsant Therapy apparatus and an Encephalography Unit will be installed as soon as they are available on the market.

The Hospital is supervised by two Boards of Visitors, one, composed of State Officials, deals with the interests of Mysore State patients, the second, composed of Magistrates, Medical Officers of important hospitals, and a few non-officials, looks after the interests of Civil Patients (non Mysore) and patients from the Military Area.

The Hospital receives paying patients from any part of India, provided there is a reasonable expectation of recovery.

Patients are to a large extent selected, and, in the circumstances, the recovery rate to direct admissions exceeds 40 per cent. This high recovery rate is the best indication of the standard of treatment.

The types of patients undergoing treatment in this hospital include the Schizophrenic—Paranoid Group, the Affective Group, the Organic Reaction Group, the Psycho-Neurotic Group, Epilepsy, Pre-senile, Senile and Arterio-Sclerotic Dementias, and Mental Deficiency.

The clinical material is ample, both for under-graduate and post-graduate teaching.

The hospital also conducts a daily Out-Patient Department, where Psycho-Neurotics and patients who do not require hospitalization, and those who have been discharged but need continuation of treatment are attended.

In addition to the above class of patients, many cases are referred to this clinic for opinion where a Psychological basis for physical symptoms is suspected. Problem Children, Delinquents, Dull and Backward Children of various grades and types, and children suffering from speech defects, etc., are also treated. The number of out-patients (new and old) attending the Out-Door Clinic during 1943, was 5,242, and during the same period 705 adults and 162 children were examined in the Psychological Laboratory. The Psychologist hopes for additional equipment in the near future, and plans for the extension of buildings are already in hand. The extension will include a Research Laboratory, and a Neurological Laboratory.

The Case Records are admirably maintained, and clinical assistants and students have an excellent opportunity of a detailed study of cases placed at their disposal.

The Hospital is recognized as a teaching institution for the M.B.B.S., and BA. (Hons.) in Psychology of the Mysore University, and the L.M.P. course of the Medical School. The hospital is also recognized as a School for post-graduate work and some research work is already being undertaken.

The staff as a whole gives the impression of high standard of efficiency.

This hospital, as at present conducted, is well adapted for both undergraduate and post-graduate teaching, but a caution is necessary. The Medical Superintendent is a highly trained and experienced teacher and clinician, but there is no Deputy Superintendent and under-study. The Superintendent is on a ten years contract which is completed in March 1945. It is doubtful if he will remain in the service of the Mysore Government, and the scale of pay is so inadequate that it will never command the services of a man of comparable ability to the present Superintendent. In short, the Bangalore Mental Hospital is a "one man show" ran by Dr. Govindaswamy. If Dr. Govindaswamy leaves Bangalore, the Mental Hospital will deteriorate, and the teaching facilities will disappear.

There is an adequate staff, on a poor scale of pay. My remarks on Nursing Personnel apply equally to this Institution as to all the others visited.

I would offer the following criticism on the layout of the Bangalore Mental Hospital. The residential quarters are much too near the hospital wards. The residence of the Medical Superintendent is less than a stone's throw from the residence of some of his subordinates. Bangalore Mental Hospital might well be accepted as a model, but these defects should be avoided in the erection of new Hospitals.

#### POONA.

At Poona, I visited the Central Mental Hospital, and the Medical School Hospital, and had interviews with Lt.-Col. B. Z. Shah, I.M.S. (Retd.), Medical Superintendent of the Mental Hospital, and Lt.-Col. S. Prall, I.M.S., Civil Surgeon and Superintendent of the Medical School Hospital.

##### Central Mental Hospital, Poona.

This institution is situated at Yeravda, about 7 miles from Poona City, and is conveniently within reach of the students of the Medical School. I understand the Poona Medical School will be up-graded to the status of a College in the near future.

The authorized accommodation is as follows:—

				Male	Female	Total
Europeans	..	..	..	141	74	215
Indian Section No. 1	..	..	..	124	127	251
Indian Section No. 2	..	..	..	456	178	584
Acute Section	..	..	..	34	11	45
Infirmary	..	..	..	79	83	132
Total				784	443	1,227

The daily average number of patients during 1943 was 1,326—almost 100 more than the authorised scale, and since the authorised scale, according to floor space is none too generous, this hospital can, at present, be described as over-crowded.

During 1943 there were only 21 Voluntary patients.

Occupational Therapy has been restricted owing to the difficulty in procuring raw materials, and Diversion Therapy for all patients has not been possible owing to lack of funds.

The total annual expenditure (1943) was Rs. 4,90,927; the amount received from paying patients was Rs. 1,47,627, so that the total cost falling on Government amounted to Rs. 3,43,300.

The annual total *per capita* cost in 1943 was Rs. 368·28, and it can therefore be assumed that in normal times the *per capita* cost was much less than one Rupee per day.

*Staff.*—The Superintendent, due to the present emergency, is a retired I. M. S. officer who does not profess to be a Psychiatrist, and the remaining members of the professional staff lack experience in Psychiatry.

In 1942 the ratio per cent. of patients discharged recovered to direct admissions was 15·89. This is a very satisfactory figure considering that the hospital has insufficient medical staff to give more than cursory attention to patients.

This institution could be converted into a first class Mental Hospital with very little expenditure. The buildings are good, well kept, and suitable. Some of the massive iron bars might well be removed.

The equipment in all departments is poor, but this can quite easily be remedied as funds become available. The outstanding deficiencies in this hospital are the lack of trained Psychiatrists, and trained nurses, and the Bombay Government will have to work on the theory that more and better trained professional personnel is the urgent need of the Central Mental Hospital at Poona.

Eight lectures, with demonstrations, are given to the students of the B. J. Medical School, Poona, by the Medical Superintendent, and, with the present staff, this hospital is quite unable to extend its teaching burden to include either M. B. students or Post-Graduate.

There is no Psychiatric Clinic at the B. J. Medical School Hospital, and at present there is no scheme to include one in the near future.

### BOMBAY.

My programme in Bombay included interviews with the Surgeon-General, the Registrar of the University, the Dean of the Medical Faculty of the University, the Dean of Seth G. S. Medical College, the Principal of the Grant Medical College, the Hon. Psychiatrists, Grant Medical College, and the Hon. Lecturer in Psychiatry, G. S. Medical College, and others.

I visited the Psychiatric Clinic, J. J. Group of Hospitals, the N. M. Mental Hospital, Thana, the Indian Institute of Psychiatry and Mental Hygiene, and the Child Guidance Clinic, Sir D. J. Tata School of Social Work.

#### Thana Mental Hospital.

This institution is situated about 20—25 miles from Bombay. Although not very old (1901) it cannot be described as a Modern Mental Hospital. Its present function is obviously one of segregation rather than of active therapy.

The daily average number of patients during 1944 was 500·2—a number considerably in excess of the authorised scale.

The ratio per cent. of patients discharged recovered to direct admissions during 1944 was 20, a figure which reflects credit on the Superintendent and his staff.



The number of Voluntary patients in 1944 was 40, and the daily average number of criminal patients for the same period was 32.5.

There is, I understand, a scheme for improving the present hospital, or alternatively to erect a new Mental Hospital. The latter alternative seems the better, but with a programme for a Post-Graduate course in Psychiatry and a large number of Undergraduates in Medicine, it would be worth while considering the erection of a modern Mental Hospital on the same lines as the Mental Hospital, Bangalore, of about 250—300 beds, and on a site accessible to both teachers and students. Almost a whole forenoon or afternoon is expended in travelling to and from this institution by those attending demonstrations.

The Out-Patient Psychiatric Clinic—J. J. Group of Hospitals, is under the direction of Dr. Masani, the Hon. Psychiatrist, who holds a D.P.M. There are 4 beds allotted for in-patients, and the average number of patients said to attend the Outdoor Clinic, is 12. The clinic functions twice weekly, and the Physician's sessions extend from 2 to 3 hours. The clinic is poorly equipped, and the House Physician (who is shared by the T. B. Clinic), is studying for his M. D. degree in Midwifery and Gynaecology.

Students for the M. B. degree attend this clinic for 7 or 8 sessions ; they have 14 lecture demonstrations at the Grant Medical College, and five demonstrations at the Thana Mental Hospital. The Hon. Physician's suggestions to increase the lectures to 50 will, no doubt, be strongly opposed, in view of the already over-loaded curriculum.

#### Seth G. S. Medical College.

There is no regular out-door Psychiatric Clinic and no beds allotted for Psychiatric cases. The Hon. Lecturer in Psychiatry visits when called upon. He is M.B. B.S. (Bombay), and did an extensive post-graduate course (18 months) in the U.S.A. His visits average two per week, and the number of patients seen average two per week.

Diploma in Psychological Medicine. I have studied very carefully the Syllabus for the Diploma of Psychological Medicine of the Bombay University, and I have had lengthy discussions on it with the Surgeon-General, Bombay, the University authorities, and the two Physicians on whom will fall the burden of teaching in Psychology and Psychiatry.

I did not discuss the teaching of Anatomy and Physiology of the Central Nervous System. There is no Psychological Department in the University, and the two Hon. Physician-Lecturers will have no Psychological Laboratory at their disposal. The out-door Psychiatric Clinics are poorly-equipped for teaching purposes, while the Mental Hospital at Thana cannot be described as of a very high standard.

The Bombay Diploma in Psychological Medicine requires no training in Experimental and Practical Psychology, but I cannot see how Psychology can be taught in a scientific manner without a Psychological Laboratory, and a well-equipped Psychological Department.

Psychiatry cannot be learned from books and didactic lectures. It must come as the result of actual contact with patients. Theories may be discussed in the Class Room, but when we attempt to fit them to conditions as they are, something is missing, and that something is skill and understanding which can only be acquired through the medium of clinical experience.

I am definitely of the opinion that teachers in Psychological Medicine must have long experience of full time clinical work in Mental Hospitals. This is particularly important in Post-Graduate instruction.

I have discussed this question in some detail. I would remind the Committee that I am discussing Principles and not individuals, and with the present facilities for teaching I cannot be convinced that the standard of the Diploma in Psychological Medicine, Bombay, will be very high, and I believe most of the authorities I have interviewed take this logical view also.

I do not suggest that the scheme be dropped. On the contrary, a beginning must be made sometime, but the authorities must press on schemes which will ensure better facilities for training.

The Superintendent, Thana Mental Hospital, has shown me Plans for a new Mental Hospital, and has given me a note embodying his suggestions for improvements. The document is too lengthy and in too great detail for inclusion in this report, but I have suggested that it be forwarded to the proper authorities for careful consideration.

It would be more convenient for teachers and students if a site for a modern Mental Hospital could be found nearer the Medical Schools.

The Travelling Allowances granted to the Honorary Physicians permit them to visit the Thana Mental Hospital once per week—occasionally twice. It takes approximately 2½ to 3 hours in travelling, and therefore the time at their disposal for Psychotherapy and Clinical Study can be but limited. Teaching at Thana Mental Hospital should obviously be the entire responsibility of the Superintendent of the Mental Hospital.

#### **Social Services in Bombay.**

A creditable start has been made, and I was greatly impressed by the work of the Child Guidance Clinic of the Sir Dorabji Tata Institute of Social Sciences. The number of children dealt with is small. During 1939, the number of new cases admitted was 63, and 11 old cases remained from 1938. In spite of these small numbers, this institution will be of great help in the training of both undergraduates and post-graduates in the study of Problem Children, and Child Psychology.

In the latest published report (1939) it was claimed that "the results of the work were gratifying, taking into account the extreme infancy of the Clinic, and the shortage of trained Staff". This has been the usual experience of most Clinics. Further development of this Child Guidance Clinic will bring forth well-trained Psychiatric Social Workers, who will be capable of treating the family members, while the Psychiatrist works with the patient.

#### **NAGPUR.**

I visited the Nagpur Mental Hospital, the Mayo Hospital and had discussions with the Inspector-General of Civil Hospitals, the Superintendent, Medical School; and the Superintendent of the Mental Hospital.

#### **The Nagpur (Central Provinces and Berar) Mental Hospital.**

The Medical Superintendent (Dr. J. Roy, M.B., D.P.M.) handed me a note with "Certain suggestions regarding the Post-War Reorganization Scheme about medical relief and health development". These are of interest and I shall enumerate some of them briefly. He says :—

(1) "It is not known definitely whether the Medical Relief Advisory Committee of the Health Survey and Development Committee will advise

the Central Government to consider " Health Problems and its Development " as an All-India problem or whether the Government of India will decide to leave these problems for the consideration of Provincial Governments for necessary action. If it is the latter, then it must be admitted that there will be no uniformity in the execution of the scheme, as some of the Provinces may not be in a position to give effect even to the most urgent needs on account of their financial position."

I agree entirely.

(2) He recommends the creation of a Mental Health Service as in the United Kingdom or United States, America, and advises :—

- (a) Compulsory Primary Education of the right type.
- (b) Creation of a Mental Health Service consisting of Psychiatrists, Psychologists and trained Social Workers.
- (c) Systematic psychometric investigation of all school-going children and necessary gradation as regards their capability to pursue different vocations. This implies specially trained vocational and industrial Psychologists.
- (d) Creation of separate and independent chairs in Psychiatry and Psychology in all the Universities. There must be under-graduate and post-graduate courses.
- (e) Psychology and Principles of Psychological Medicine must be included in the curricula of Medical Education.
- (f) Children's Clinics must be as wide-spread as possible.

He also strongly advocates that " the Health Problem (both Mental and Physical) be treated and dealt with as a Central Subject by the Central Government to ensure uniformity, as otherwise, it is just possible that some of the Provincial Governments may find it beyond their financial resources to give full effect to the scheme for which grant of a subvention might become necessary.

It is not possible to enumerate all of Dr. Roy's observations. The above would be the ideal, and in due course will be practicable, but it is more than a quarter of a century since the United States of America and United Kingdom, took up Mental Health problems, and since the subject, has, so far been shirked in India, we cannot expect the ideal scheme to materialise for some considerable time.

The Mental Hospital has accommodation for 600 patients (beds do not yet exist for all patients, and in the Isolation Block they are of cement )—Males 458, Females 142. There is no other Mental Hospital in the Central Provinces. The 1931 Census revealed the Insane Population of the Central Provinces to be 5,033 (Males 3,161, Females 1,872). There would appear to be a clear case for increasing the accommodation.

The hospital is of a very poor type, and some of the buildings date from the first half of the Nineteenth Century. The ratio per cent. of patients discharged recovered direct admissions during 1944 was 21.15. In view of the numerous handicaps, this figure is very creditable.

The following is the list of defects, as prepared by the Medical Superintendent :—

- (i) Inadequacy of the Medical Staff.
- (ii) Inadequacy of the Nursing Staff.
- (iii) Very poor quality of the Attendant Staff.
- (iv) No Neuro-Surgeon, no Biochemist, no Pathologist. (Laboratory buildings have been completed, but the scale of pay is not likely to attract a good Bio-Chemist).
- (v) Some of the buildings are of the archaic type.
- (vi) There are no Occupational Therapists nor Physical Culturists.
- (vii) Inadequacy of menial establishment.
- (viii) Very low scale of pay for all Staff (Medical, Nursing, Attendants).
- (ix) Mental Defectives have to be admitted along with the Psychotic in the same hospital, as a result of the definition "Lunatic" [Section 3 (4) of the Indian Lunacy Act, 1912].

I do not think the Superintendent has been ungenerous. I might add that, in my opinion, it is the poorest type of Mental Hospital, I have visited in India, which has Government support. In his observations the Medical Superintendent states : "From time to time the unsatisfactory state of affairs had been brought to notice of the Government, and a six-year planned scheme was submitted in 1938, to which effect is being given, as far as war conditions will permit." He concludes with the following : "I made it clear at that time that my recommendations were only the first stage towards making this hospital a hospital for Mental Diseases in fact as well as in name".

Students for the L. M. P. Diploma receive five lectures, which is included as a branch of Medical Jurisprudence, but there is an advance on Bengal—the Medical Superintendent of the Mental Hospital is the Lecturer.

There is a proposal under consideration to include a short course in Psychology in the curriculum of the Medical School Students, Nagpur. This is a step in the right direction.

There are no facilities for Post-Graduate study in Nagpur, and there are, so far, no Psychiatric units in the General Hospitals.

My General Remarks apply to Nagpur.

It appears to me to be a mistake to go on with piecemeal expenditure on a Mental Hospital, which for all practical purposes is obsolete. The present Mental Hospital, with certain improvements, might well be converted into a home for Senile and Chronic cases, but for the treatment of the Psychoses and Psycho-neuroses, and a teaching programme, a new Mental Hospital of 500 beds (sited with a view to ultimate extension to 1,000 beds) should be the immediate target.

#### AGRA.

At Agra I had lengthy discussions with Major-General Buckley, Principal of the Agra Medical College, some of the Professorial Staff of the Medical College, and Dr. Lal, Superintendent of the Mental Hospital.

#### Mental Hospital.

The accommodation in this hospital is for 600 patients, and the daily average number under treatment during 1944 was 517.32.

There are no Voluntary patients and no Criminal patients.

This hospital stands in need of many improvements. The Superintendent is enthusiastic, and is doing his utmost to make progress. He is M.B. B.S., and had a short course of training at the European Mental Hospital, Ranchi, before he took over charge of the hospital about two years ago, and he hopes that the United Provinces Government will grant him facilities to proceed to the United Kingdom to obtain the Diploma in Psychological Medicine at an early date.

I propose to make some quotations from his answers to my Questionnaire. He states :—

(1) "There are no nursing arrangements of any sort. Even patients with Enteric, Pneumonia and other debilitating diseases get no nursing. They are at the mercy of so-called attendants, popular idea being that they are just like Warders of Jails. They hesitate to touch patients when unclean, not to mention giving them bedpans or urinals, or cleaning them when necessary. They look to the sweepers to do all this for the patients. It is difficult to undertake any specialised treatment without team work, the main constituents of which should be efficient nursing and medical care. For special treatment like Cardiazol-shock, Continuous Narcosis, Pyretotherapy, and Hydrotherapy, careful watching and tending is necessary during and after treatment. To carry on this job it is necessary that trained nurses should be appointed in the Male Section and trained female nurses should be appointed in the Female Section.....".

"In my opinion due to the above difficulties it is necessary that nurses be appointed for the Mental Hospital before any real attempt to give modern specialised treatment can be seriously undertaken. Nine male nurses for the Male Section of this hospital, and six female nurses for the Female Section should be appointed in the first instance."

"Hydrotherapy—In this hospital there is only one Hydrotherapy Tub in the Male Section and one in the Female Section. The result is that not more than one patient can be treated in each Section. For this treatment to be effective it is necessary that the patients should be in the bath for 6—10 hours.....I think there should be at least nine tubs before the bare needs could be met with."

The Superintendent has constructive proposals for Occupational Therapy, Recreational Therapy, etc., and he has hopes that they will receive sympathetic consideration in the near future.

The Superintendent goes on to state :—

"Increase in the number of attendants is absolutely necessary in order to reduce restraint to a minimum. The other Mental Hospitals spend double the sum that is spent in this hospital per patient on supervision. Unless the number of attendants is doubled, the restraint abolished, outbursts of a violence and destructive tendencies of the patients cannot be stopped, and unless the patients have a feeling of freedom, the progress of mental deterioration in the mentally sick cannot be effectively checked."

"Staff—There are only two Medical Officers in the Male Section with a population of about 400 patients—at least two more Medical Officers are required to carry out special treatment, and look after the patients effectively—one should be Psychologist. One additional Medical Officer for the Female Section is an absolute necessity."

**"Diet"**—The diet of Class III patients is very poor as compared with other hospitals. They have hardly any changes. The same menu of dal roti in the morning, and roti sag in the evening goes on, day in and day out, and one can imagine the monotony of the meals and the patient's feelings and reactions. Other Mental Hospitals spend about double the sum per patient that is spent here on diet. Better diet, with occasional changes, will improve the physical health, and the mental health, too, will certainly improve."

The Medical Superintendent has submitted the diet schedule of the Indian Mental Hospital, Ranchi, and has invited the attention of the authorities to the marked difference. He has also submitted scheme for improvement in the kitchens.

He has also suggested that an apparatus for electrical convulsant therapy be installed.

I need hardly say that I endorse the condemnations enumerated by the Medical Superintendent, and I am of the opinion that they are worthy of consideration from the Medico-Legal as well as the humane point of view.

It might be mentioned that in this hospital a very large number of the patients have been suffering from anklyostomiasis. This difficult problem is being tackled by the staff, but it is still prevalent to an alarming extent. I think further comment on this institution is superfluous.

A course of 18 lectures is given to the M. B. students of the Agra Medical College, the Lucknow Medical College, and the Lady Hardinge Medical College, Delhi, and three lectures in normal Psychology are given to 2nd year students of the Agra Medical College.

Post-Graduate teaching is not contemplated at this school, and in my opinion, the burden of teaching M. B. students is too heavy, and cannot be carried out efficiently by the present Superintendent until he has taken the D.P.M. course himself.

The Superintendent, however, has very progressive views, and has the makings of a first class Superintendent and Clinical teacher. He deserves every encouragement, and he should be given every facility to carry out his study programme.

### LAHORE.

At Lahore I visited the Punjab Mental Hospital, and had lengthy interviews with the Inspector-General of Civil Hospitals, and a Conference was also arranged by the Inspector-General of Civil Hospitals, which was attended by the Principal, K. E. Medical College, Lahore, the Principal, Balak Ram Medical College, Lahore, the Principal, Glancy Medical College, Amritsar, the Principal, Arya Medical School, Ludhiana, the Registrar, Punjab University, and the Secretary, Punjab State Medical Faculty.

#### Punjab Mental Hospital.

This hospital has an authorised accommodation for 1,300 patients, and the daily average number under treatment during 1943 was 1,226·14.

The present Medical Superintendent is a retired P. C. M. S. Officer, and holds the degree of M.B.B.S. Before appointment to this onerous post (the Punjab Mental Hospital is one of the largest in India) he had no experience whatsoever of Mental Hospitals or Psychiatry.

I propose to quote from a statement prepared by the Superintendent in answer to my Questionnaire.

(1). "The Medical Staff is most inadequate. This becomes very evident when one compares it with the Staff of the Mayo Hospital, e.g., for 85 beds for sane, responsive and co-operating patients in a section of the Mayo Hospital there are, one Physician, one Clinical Assistant, and three House Surgeons, besides fully qualified nurses, etc. This staff is purely for the treatment of the cases, and have nothing to do with administrative, or Laboratory work, etc. In the Mental Hospital there are 1,225 patients with only one Medical Superintendent, one Deputy Superintendent, and one Assistant Superintendent, on general duty, recently engaged, one Lady Doctor, two Sub-Assistant Surgeons, and two part-time House Surgeons who work for a couple of hours only. The patients are resistive, mute, unresponsive, unclean and filthy in their habits, and some have to be tube-fed. They have to be looked after, treated for physical ailments and mental troubles..... A thousand and one other administrative duties are to be carried out by this meagre staff. They (the Medical Staff) fail or are rather forced into the habit of neglecting duties and then become callous, and finally their emotional apathy becomes level with that of a Schizophrenic. It will take a doctor 20 hours to devote one minute to a lot of 1,200 patients."

The Superintendent goes on to say—

"If any of our patients suffers from a physical ailment which we cannot properly diagnose for lack of facilities or lack of specialized knowledge, we send such cases to the Mayo Hospital. Generally there is great difficulty, I do not say reluctance, for, as a rule, a bed is not available."

The Superintendent further points out that although the Asylum has been converted into a so-called hospital, the "contents of a bottle cannot be altered by changing the label." He says: "the same bars, the same rotten cells, the same counterparts of Jail Warders as Attendants remain. The trained nurse, the sympathetic Warders, the specially qualified doctor, are all conspicuous by their absence. There are no special facilities or apparatus for newly discovered forms of mental treatment." He points out that the hospital is a detention camp for criminal cases, and an asylum for demented non-criminal cases. He suggests that a Visiting Surgeon and Physician be appointed from the Mayo Hospital, but even with this arrangement, he considers that the Staff should at least be doubled.

There are no outdoor Psychiatric Clinics connected with General Hospitals in Lahore, and I agree with the Superintendent when he says that it will be several years before such Clinics can enter the realm of practical politics. He rightly states that "the training received by our Medical men in Psychiatry is very scanty, and they are likely to make a muddle of it if they are encouraged to meddle in this line."

There are three new Wards with accommodation for 300 patients in this hospital (completed in 1937), and they are of a good type. The accommodation for the remaining 1,000 patients can only be described as deplorable. There is almost a 100 per cent. infestation of *Ascaris Lumbricoides* in the hospital population. An entirely new hospital built on modern lines is an urgent necessity.

The Medical Superintendent admits his limitations. He has no knowledge of Mental Diseases, and his own statements reveal how such a situation reacts on a subordinate staff. He is most unhappy in the appointment, and is merely there from a sense of duty in the present emergency. I am of the opinion that the most urgent requirement in this hospital is the appointment of a qualified Medical Superintendent.

The Medical Superintendent is responsible for the training of 90 M.B. B.S., and 60 L.S.M.F. students per annum. He sums up the situation himself when he states that the "training received is very scanty".

There are at present no facilities in Lahore for Postgraduate teaching in Psychological Medicine, and none is contemplated in the near future.

My limited Survey of the conditions in the Punjab Mental Hospital convinces me that in this institution adequate understanding of Mental Disorders, and adequate Therapy are both wanting. The problem is very complex but urgent.

After my visit to the Punjab Mental Hospital I read in the daily paper that the Provincial Government had a scheme for relieving the congestion and overcrowding in Punjab Jails by opening more jails under their first five-year plan. Provision is to be made for 30,000 prisoners, and in place of the old fashioned jail buildings, modern structures have been planned which will have flush latrines, etc.

These jails will have organized Occupational Therapy Schemes, and expansion of the present Jail libraries and education staff.

The Punjab Mental Hospital is worse than many of the Central Jails I have visited in India. The Government of the Punjab will no doubt exercise, in some measure, the same solicitude for unfortunate patients whose only crime is that they suffer from Mental Diseases, which, in the majority of cases, can be cured or relieved.

#### RANCHI.

##### Indian Mental Hospital, Ranchi.

I visited this hospital on 6th February, 1945.

The daily average number of patients during 1943-44 was 1297·82, (males 1,034·41, females 263·41) of whom 424·04 (males 389·72, females 34·32) were Criminal patients.

This hospital is of a very high standard and compares favourably with the new Mental Hospital in Bangalore. It is in advance of the Bangalore Mental Hospital, as all patients are allowed beds, bed-linen and mattresses, whereas a large number of the patients in the Bangalore Mental Hospital sleep on mats on the floor.

The Medical Superintendent is a very able member of the Provincial Medical Service, Bihar, and holds the degree of M. B. (Cal.) and the D.T.M. & H. (Lond.). He was on the Staff of the European Mental Hospital for some time as Medical Officer, and later as Deputy Superintendent. He is anxious to obtain and prepare to study for a Diploma in Psychological Medicine in the United Kingdom, and I consider he is the right type for employment in a Mental Hospital Service.

The first Deputy Superintendent holds the M. D. in Psychological Medicine of Patna University, but has little clinical experience. I have stressed the need for a high standard and uniformity in M.D. degrees in India, and until such uniformity is attained, I think such Degrees cannot be seriously considered when making appointments.

The second Deputy Superintendent is M. B. (Cal.), with no special training in Psychiatry, while the remaining five Medical Officers hold the L.M.P. Diploma.

In the Female Section there is a Matron and four nurses—all general trained—and the management of the patients and the Wards is superior to any other hospital I have visited on this tour.



There are no Occupational Therapists, but a well organized Work Department exists and its beneficial effects are evident. The department gives an impression of industry and contentment.

The Diversional Therapy Department is being developed, and the hospital has its own Cinema, and well-equipped entertainment rooms. These are, at present, located in one of the Wards, but a separate unit is desirable, and I understood this will be considered as soon as building programmes can return to normal.

The per capita rate per annum is Rs. 570-10-0 — much higher than any other Mental Hospital for Indians only, but the additional expenditure is reflected in the whole atmosphere of the institution — it is a Mental Hospital.

The ratio per cent. of cases discharged recovered to direct admissions in 1943-44 was 24·53, a very creditable figure, in view of the large number of Criminal patients, who can only be discharged after their individual cases have been considered by Government. It is the exception for any criminal cases to be discharged in less than five years from the date of their admission to hospital.

The students from Patna University attend the hospital for a period of three weeks, for what is described as intensive training in Mental Diseases in accordance with the Curriculum passed by the Board of Studies of the Patna University. The number of lectures per Course is 20, and 34 students attend in two batches. I consider it is not fair to call upon the present Medical Superintendent to conduct these courses of instruction. It is a very heavy burden for which, in my opinion, he is not yet equipped. I do not consider Post-Graduate Students would benefit from attendance at this institution until the standard of the Professional Group has been raised.

#### **European Mental Hospital, Ranchi.**

This hospital is built on modern lines and has accommodation for 300 patients. It was visited recently by the Consultant Psychiatrist of the British Army, who has had a vast experience of Mental Hospitals all over the World. He considers that the European Mental Hospital, Ranchi, compares favourably with any hospital he has visited. Other eminent Psychiatrists have made similar comments.

The Superintendent is a Specialist in Psychiatry. The Deputy Superintendent is on Military Service and is a Graded Psychiatrist, and the two House Physicians have 21 years and 16 years service in the Hospital respectively. The present Deputy Superintendent is employed as a temporary measure, but is not a Psychiatrist.

There is at present a Military Wing of 60 beds and the Officer Commanding is an experienced Psychiatrist, a former Deputy Superintendent of one of the largest Mental Hospitals in England, and Psychiatrist to the Scottish Command. There is also one R. A. M. C. officer who has a limited knowledge of Psychiatry.

During the past two years the ratio per cent. of patients discharged recovered to direct admissions averaged 56·33, and 4 per cent. were discharged improved.

The number of Voluntary patients admitted during 1943-44 was 113 as compared with 86 the previous year. In both years there were more Voluntary patients than Committed patients.

The per capita cost per annum in 1943-44 (exclusive of interest on loans) was Rs. 2,015, but in previous years was between Rs. 1,200 and Rs. 1,300.

The Hospital is well staffed.

**Nursing.**—One Matron and twelve General Trained Nurses. The Matron holds triple qualifications—General Training, C.M.B., and the Certificate of Proficiency in Mental Nursing of the Royal Medical-Psychological Association. Of the twelve Nurses seven hold the Certificate of Proficiency in Mental Nursing, and had it not been for the present emergency with constant changes among the junior Sisters, all would have been in possession of the Royal Medico-Psychological Association Certificates.

**Attendants.**—There are 94 attendants (males 46, females 48) most of whom have gained the First Aid Certificate, and the Home Nursing Certificate (St. John's Ambulance), but, in addition, there are 148 private attendants (males 57, females 91).

This high proportion of nurses and attendants is to a large extent the reason for the success of the Hospital as a treatment centre. Seclusion and restraint are not permitted, and all maniacal or excitable cases are treated by hydrotherapy or continuous narcosis.

The Occupational Therapy Department is in charge of a General Trained Sister who holds a diploma in Occupational Therapy and there are in addition two full-time Occupational Therapists. There are 25 instructors in the various arts and crafts.

**Diversion.**—This department is highly developed and includes a modern Gymnasium under the control of a qualified physical culturist. There are entertainment halls, library, and other amenities conducted by qualified personnel. The Cinema at the Indian Mental Hospital is frequently placed at the disposal of this hospital.

**Outdoor Amusement.**—There are tennis courts, football, hockey, and cricket grounds situated outside the hospital.

**Chapels.**—There are Church of England and Roman Catholic Chapels and Chaplains of both denominations are detailed for duty in the hospital.

**Treatment.**—All modern methods of treatment are employed, and there are electrical convulsant Therapy units in both Male and Female Sections, and as soon as circumstances permit, an electro-encephalography unit will be installed.

There is a well-equipped operation theatre and laboratories, etc. A special Psychological Laboratory has been built, but there is, at present, no Psychologist on the staff, and the Medical Staff have little time for experimental work, as they are fully occupied in the Wards.

**Teaching.**—Post-Graduate courses are held, and during 1943-44 seven students attended the Course of Instruction. The Course includes Psychiatry (Clinical and Theoretical), Forensic Psychiatry, and Mental Hospital Administration. The instruction covers the ground in Psychiatry only, for the D.P.M. or the M. D. in Psychological Medicine. There are no facilities for the study of advanced Anatomy, Physiology and Histology of the Central Nervous System, or Experimental Psychology.

The Hospital is recognised as a training school for the D.P.M. by the University of London and as a Teaching School for Nurses by the Royal Medico-Psychological Association.

Six Post-graduate students could be trained per annum, and the Course would cover the requirements for the Medico-Psychological Certificate, or the six months hospital residence required by the regulations for most Diplomate in Psychological Medicine. Students preparing to take the Diploma in Psychological Medicine would require to proceed to the United Kingdom to complete the requisite course.

A sum of Rs. 100 per month per student is payable to the Board of Trustees of the Hospital.

### GENERAL REMARKS.

#### *The Mental Hospitals.*

Mental Hospital Administration is a Speciality to which men should devote their entire lives. They can then formulate policies arising from their experience and calculated to bring advantage to the patients.

Industry has pointed the way for hospital administration. Efficient management is an indispensable factor in organization. Industrial leaders insist that a man who has been thoroughly trained in a special line of business, and has shown characteristics that stamp him as a leader, is cheap at any price. He is the one to promote business and safeguard industrial interest, but Government rarely applies this lesson. Seven of the largest Mental Hospitals in India have men appointed as Superintendents at salaries that a first class Mechanic in Tatas Works would scorn, six of them have little or no Post-Graduate experience or training in Psychological Medicine, and yet these men have been charged with the supervision of large hospitals, and what is more important, human lives. The Deputy Superintendents and subordinate Medical Staff are more or less of a temporary nature, utterly untrained in Psychiatry. Broadly speaking, the Institutions function, stagnant and dead, with a routine custodial care, in some instances of a very poor standard, meted out to patients.

The main interest, in the past appears to have been economic, but, in the future, the professional group must be the dominant one.

Every Mental Hospital which I have visited in India is disgracefully under-staffed. They have scarcely enough professional workers to give more than cursory attention to the patients, to say nothing of carrying a teaching burden. With an average ratio of 1 Medical Officer to 200 patients or more, there can be little time for the instruction of students. Government will have to work on the theory that more and better trained professional personnel is the urgent need of Mental Hospitals. The policy of increasing bed capacity, which incidentally has led to gross overcrowding in most of the Mental Hospitals rather than personnel, has been stressed in the past, but the cure of mental patients and the prevention of Mental Diseases will not be accomplished by the use of bricks and mortar.

Two Responsibilities confront us—

(i) Instruction of Personnel.

(ii) Instruction of Students who come for practical experience in Psychiatry.

The resources of the Medical Schools and Mental Hospitals in India do not permit of Post-Graduate teaching, and for the training of personnel for the Mental Hospitals, India will have to rely on foreign assistance for some years to come—ten years at least.

The Course of Instruction for a Diploma in Psychological Medicine must embody an entire Mental Hygiene Scheme. Emphasis on prophylaxis and prevention must be in line with the principles of modern preventive medicine.

This is a suitable time for Government to take account of stock, overhaul resources, and re-chart the Course for the next 30 years. Public opinion will soon demand that patients in Government Mental Hospitals must be cared for by experienced and well-trained individuals.

Medical Superintendent.—It is desirable to have a Superintendent who is well qualified. Every Psychiatrist has seen cases in which eye specialists have tried to correct failing vision by refraction in a patient suffering from G. P. I. Surgeons have frequently been guilty of operating on hysterics

and psycho hitatrists have called the complaints of patients, somatic delusion until the patient finally died of cancer.

In addition to holding the Diploma in Psychological Medicine, it would be desirable for the Medical Superintendent to hold a higher degree in Medicine or Surgery.

The Deputy Superintendents should also be highly qualified men with a D. P. M. and capable of understudying the Superintendent. There should be a Deputy Superintendent in both Male and Female Sections of every Mental Hospital.

The Senior Medical Officers in both Male and Female Sections should hold the Diploma in Psychological Medicine, and understudy the Deputy Superintendent.

The ultimate aim should be that all Medical Officers must obtain the Diploma in Psychological Medicine, and it is to be hoped that the Universities of Bombay and Calcutta will, in the course of a few years, be able to grant the diplomas, and, perhaps later, the Madras and Punjab Universities. I think this rush by all Provincial Universities to institute Post-Graduate diploma is premature. The trained personnel will not be available for years.

There are four very old Medical Schools in Scotland with much greater facilities for teaching Psychiatry than any School in India, but, so far, only Edinburgh University has instituted a Diploma in Psychiatry.

In London there are only two Schools which conduct courses for the Diploma in Psychological Medicine, and, as far as I am aware, Leeds and Manchester are the only Universities in England which have a Diploma in Psychological Medicine Course. The London University and the Royal College of Physicians and Surgeons grant a Diploma in Psychological Medicine, but merely function as examining bodies.

There is no uniformity in the teaching of Psychiatry in any of the Schools in India. Carefully thought out courses of instruction are requisite for such a programme both for M. B. and Post-Graduate students. It is no use pretending that Psychological Medicine is being taught anywhere in India. Students cannot be exploited much longer, but must be given something that will repay them for their hard work and sacrifices.

My tour has brought home to me that in a teaching programme the Mental Hospital will form the one stable factor. Clinics may come and go, organizations for the correction of this and that difficulty may come into existence, flourish and fade, but the Mental Hospital goes on hence the need for a modern Mental Hospital within easy reach of the Medical School. The Mental Hospital can become a tower of strength in the Psychiatric world if it will turn its attention to a more active Psychiatric leadership.

I have not been convinced that the utilization of Honorary Physicians in India is a success in a teaching programme. As already pointed out, one finds that Honorary Physicians are, as a rule, very jealous of their prerogatives, but take their responsibilities lightly. There are, of course, exceptions.

I have had talks with several "Honorary Physicians", and there is a feeling of discontent among them. Most of them are overburdened with personal problems and preoccupied with earning a livelihood. They cannot give of their best to a teaching programme, if harassed by financial worries, and no Government has the right to ask it.

To obtain real service in Mental Hospitals, Teaching Programmes, Psychiatric Clinics, Social Services, etc., it is essential to have a Mental Health

Service, and that Medical Officers should be specially recruited for it. Officers entering this Service must be made to realize that they are entering a very fine service for which they will have to train rigorously.

It is essential that a systematic plan be under the control of one individual, whose main business and responsibility it is. Without such centralization we shall get wasted effort and duplication. It will be necessary to visualize a plan which may take years to mature. In India, it is obvious that the Medical Superintendents of Mental Hospitals must assume greater responsibilities. The Mental Hospitals have become isolated units, having little contact with the Community they serve, and in most cases, are objects of fear and suspicion.

The Medical Superintendent of the Mental Hospital must become the Chief Medical Officer, Mental Health Service in his area or Province, and become the adviser in Mental Health matters to the Chief Administrative Medical Officer. In addition he should be ex-officio the Senior Physician and supervise the work of all Psychiatric Clinics. He should be the individual to coordinate and lead any Mental Hygiene movement, and to supervise the work of Social Services. As the Mental Health Service expands, he may have to take over the Mental Health Department in the office of the Chief Administrative Medical Officer.

He should therefore have competent Deputy Superintendents, so that he can be at liberty to inaugurate and carry out, as rapidly as circumstances will permit, a comprehensive programme dealing with all general phases of the Mental Diseases problem and education.

Every Mental Hospital in the vicinity of a Medical School must become a teaching hospital, and the professional group in such a hospital must be the dominant one. Here again the Medical Superintendent must be the Director of Clinical Work.

The teaching hospital, from a therapeutic point of view, is superior to the one which does not have an educational outlook. The mere presence of a group of young students, interested, enthusiastic, and intellectually alive, prevents hospital inertia. Teaching and being taught stimulates every member of the professional staff, and keeps the entire organisation on the *qui vive*. The sum total to an educational programme is to place the patient and his needs on a higher plan.

No one will deny the necessity for highly trained Specialists in the various fields of Psychiatry in India. At present their number is negligible, and of these, the more experienced Clinicians are nearing the age of retirement.

The service must be made attractive, and graduates in medicine with a satisfactory academic career behind them must be selected. They should be given a resident appointment in a Mental Hospital in India for 6 to 12 months and then sent to the U. K. or the U. S. A. for Post-Graduate training. If twelve scholarships were granted annually for ten years there would be a nucleus of men to take over the responsible posts as Superintendents, and Deputy Superintendents, and later leadership in this Speciality. The practice of granting Study Leave to Graduates in the Medical Services might be continued, but few can avail themselves of the privilege. The Post Graduate student has to expend a large sum in Travelling Expenses, which, in many cases, is borrowed. He hopes to recompense himself later in Practice, but this is not feasible in a Mental Service, and must be taken into account when Graduates are sent abroad. No student should receive any fellowship in excess of maintenance, cost of books, and instruction. To pay any one to take an education indicates that the educational offering is not very valuable.

Men for Subordinate Posts may be trained in this country, and until such time as Medical Colleges can institute a uniform and practicable syllabus for a Diploma in Psychological Medicine, I would suggest that Medical Officers be encouraged to obtain the Certificate Psychological Medicine (M.P.C.) granted by the Royal Medico-Psychological Association. There is a strong membership of the Indian Division of the Royal Medico-Psychological Association, and there would be no difficulty in arranging for the examination to be held in India.

A beginning in this modest manner (it was done in the U. K.) would be preferable to granting Diplomata of a low standard which might later prove an embarrassment to Government. The more able men who obtain the M.P.C. would probably later proceed to a Diploma in Psychological Medicine. As an incentive Medical Officers who obtain a D.P.M. or M.P.C. should be granted a Special Pay. All holders of the D.P.M. in the Mental Service in the U. K. received an annual allowance of £50. If Universities are to grant an M. D. degree in Psychological Medicine, there should be a uniform high standard for the whole of India.

The general standard of the Mental Hospitals I have seen, is poor. Economic factors will always affect scientific considerations. It may not be possible to do as much Psychiatric research as one desires because sufficient money is not available, but certainly the quality of professional work is subject to no such limitations. There may be too few physicians, but this is no legitimate reason why administrative medical officers should not get the best ones available, and hold them to a high level of professional performance. Financial security is not the first requisite to hospital progress — the desire and enthusiasm for progressive change must always come first.

There is an urgent necessity for better trained Nurses. On the nursing staff of a Mental Hospital depends the harmony which exists between the hospital and patient, and that may mean the difference between success and failure of treatment. If a patient is constantly irritated by tactless handling, exasperated by petty tyrannies, and annoyed by inflexible rules enforced by poorly informed attendants, and improperly trained nurses, he soon develops the idea that his welfare is not the first consideration. There is a type of Psychological abuse of mental patients which may be much more disastrous than any kind of physical abuse.

An institution with a poorly trained and inadequate nursing staff starts with a definite handicap which will seriously interfere with its efforts. The social environment as represented by the nurse and attendant is of much greater importance than the colour of the Wards, selection of the furniture, cinemas, radios, etc. Pleasant-surroundings are a hollow mockery when a small minded unintelligent attendant constantly thwarts the patient in his attempts to enjoy them.

The Psychiatric Nurse performs a more difficult and exacting task than any General Nurse, and she should have correspondingly better educational standards. Mental Hospitals have not taken their educational responsibilities too seriously. There can be no valid excuse for the failure of a Mental Hospital to instruct its own people. Machinery exists in India for the granting of a Certificate for Proficiency in Mental Nursing by the Royal Medico-Psychological Association, but, so far, only the European Mental Hospital at Ranchi has trained nurses for this Certificate. All Mental Hospitals in India which employ General Trained nurses should take immediate steps to procure recognition as training schools by the Association, and they should

train and encourage their nurses to obtain the Certificate. This will mean a sacrifice in time, but administrative Medical Officers should bring home to superintendents of Mental Hospitals that they have a responsibility in this field, and must prepare to carry out that responsibility. The Board of Trustees of the European Mental Hospital at Ranchi stipulate that all Nursing Sisters must, during an early stage of their Service, obtain the Certificate of Proficiency in Mental Nursing, and the majority of them did. Before the war there were numerous indications that good nurses were turning to Psychiatric nursing, and there was a large waiting list of good candidates for employment at the European Mental Hospital. This may be due, in some respect, to the reputation this institution has acquired, and to the generous terms of their employment. The aim should be that all wards, male and female, should have a carefully selected, well-trained Psychiatric Nurse in charge. This may take years to achieve in India, but I maintain that it is practicable.

Given a competent Psychiatric Nurse in every ward, the question of attendants remains. Where are we to get the Ward Personnel? Are we to go on with the present Personnel, who do not receive training even of the most superficial character?

It is surprising that many of the individuals placed in a ward of filthy, destructive, violent, profane, noisy patients, can maintain their emotional equilibrium and remain human. It is only because of their fundamental decency, and not because they have any spark of real understanding of the basic situation. I have been connected with Mental Hospitals too long not to appreciate the difficulties inherent in this situation, but, in spite of these difficulties, I cannot feel that attempts to change the situation are impossible. Something can and must be done to increase the number and improve the quality of Ward Personnel. At the European Mental Hospital, Ranchi, all attendants, male and female, are required to attend courses of instruction in First Aid, and Home Nursing, and a very large number have already obtained the St. John's Ambulance Certificate in both subjects, and it is amazing what this small beginning has achieved. The nursing care and treatment of the patients improved to an enormous extent. The utilization of young and immature people—and there is much of it—for ward work, is, in my opinion, a very questionable procedure. Adolescents should not be in charge of Psychiatric patients. They are not sufficiently stabilized emotionally to be placed in such a situation.

The Indian Division of the Royal Medico-Psychological Association have under consideration a scheme for the granting of a Certificate to Ward Attendants, and at Ranchi it is proposed that an attendant would in his first year of service obtain the First Aid Certificate, in the second the Home Nursing Certificate, and in the third the Certificate in Mental Nursing. Hand Books in the Vernacular have already been published.

For the Certificate in Mental Nursing the Course would be of an elementary character, and a course of about 14 lectures would suffice. My suggestion for the lectures is as follows:—

1. History of Mental Disorder.
2. Mental Disease as a Public Health Problem.
3. The Infection—Exhaustion Psychoses.
4. The Toxic Psychoses.
5. General Paresis.
6. The Symptomatic Psychoses.

7. Arteriosclerotic and Senile Psychoses.
8. Borderland States.
9. Manic-depressive Psychoses.
10. Schizophrenia.
11. What is Mental Hygiene?
12. Mental Hygiene of Childhood.
13. Mental Hygiene of Adolescence.
14. The Human Personality.

Both theoretical and practical instructions are essential. It will be seen that the above scheme of lectures, if accepted, will introduce the Attendant to Psychiatry through the Psychoses which have a direct physical causation. The simpler the course, and the more gradually it develops from the physical to the highly complex psychological, the more successful it will be. The war has, unfortunately, delayed this scheme, but it is hoped that the Indian Division of the Royal Medico-Psychological Association will meet this year. Most of the Medical Superintendents of Mental Hospitals in India and Ceylon are members of the Association.

The custom of generalizing about ratios of Ward Personnel which takes no account of admission and discharge rates, the kind of service given to the patient, or the number of essential subsidiary departments carried on, is a mistake. All of these must be considered when Ward Personnel ratios are being worked out. (See notes under European Mental Hospital, Ranchi).

Psychotics adjust themselves at different levels.

- A. Social Recovery — (the ideal aim).
- B. Social Institutional Adjustment.
- C. Institutional Adjustment.
- D. Deterioration.

It was depressing to find the enormous number of patients who have "deteriorated", and what was worse, the general attitude of pessimism and indifference which characterised the situation.

The standards of care which prevail in the hospital are responsible to a considerable extent for the level at which patients adjust. If the ideal of the institution is the discharge of patients, if the professional staff is held to a high level of accountability for such discharges, and if the administration is called upon to defend continued residence in the institution, the last three groups will not be as large as they are. The fourth group is a definite indictment of the therapeutic standards in the Mental Hospitals in India. The vast majority of these patients have been permitted to slump into this condition of deterioration because the routine was not sufficiently insistent and compelling to keep them in reality even for brief intervals.

In all the hospitals I visited there is a need for a more systematic and better conceived plan of work therapy. None of them except the European Mental Hospital, Ranchi, employ Occupational Therapists. In advanced countries, Occupational Therapy has developed to the point where its representatives have become indispensable to many General Hospitals, Tubercular, Orthopaedic, and Mental Hospitals. In Occupational Therapy we have a powerful therapeutic weapon for the Psychiatric patient. Organized systematic work is better treatment than the careless haphazard occupation in some of the hospitals. The important thing is to create throughout the hospital an atmosphere of industry, and to make occupation an activity that is approved by the patients.



**More can be done in the way of Diversional Therapy. A Mental Hospital with all modern types of therapy equipment, and installation is still a house of sorrow and discontent. Everything that can serve to alleviate any of this discontent should be utilized. Entertainment is therapeutic, it specialises the patients' mind and interest, and it is bringing him back to reality. Money spent on entertainment is a good investment, and the budget allotments under this head should be generous. Suitable programmes can readily be made available if the necessary funds are forthcoming.**

All arteriosclerotic, decrepit and senile patients should be housed separately. They are fundamentally medical and nursing problems, and should be under the supervision of the Medical Services. Kindly and humane custodial care in special Homes would be more economical than treating them in Mental Hospitals. At least 50 per cent. of the patients in Mental Hospitals in India could be cared for in such Homes.

In the U. K. there has been a definite demand on the part of the public for psychiatric clinics, and fortunately there has been a definite swing away from the extravagant claims of early exponents of Mental Hygiene towards a recognition of the limits of preventive Psychiatry. While no specific preventive measures have been discovered enough sound knowledge has been accumulated to show that a continuance and extension of outdoor clinics is a logical procedure.

The Directorship of either an adult or child clinic is a full-time position. A successful Clinic will not remain so long, if it is the Secondary responsibility of anyone. The immediate establishment of Psychiatric Clinics in General Hospitals is not feasible in India at present, as there is no trained personnel. To establish them before efficient personnel is available would be extremely bad propaganda. I have already made the suggestion that the Medical Superintendents of Mental Hospitals should be ex-officio the Senior Physicians of all such Clinics. There is no reason why the General Hospital should not, in due course, bear its share of mental disease prevention. It is a problem of Public Health, and as such is of interest to every agency interested in this important activity. The General Hospital sees patients in the pre-Psychotic stage, and they are in a favourable position to influence the education of Psychiatrists. When trained personnel is available, it is to be hoped that Psychiatric Departments in General Hospitals will be the rule rather than the exception.

These can only come when sufficient trained Psychiatrists and Social Workers are available. The collaboration of Psychiatrist and Social Worker results in a therapeutic programme which is better balanced than is possible when each works alone.

The actual contact with patients in the early stages of maladjustment will be through the General Practitioner, Teacher, Juvenile Courts, Probation Officer, Police, Social Worker, Y. M. C. A., Y. W. C. A., Boy Scouts, Girl Guides and Parents, but the Mental Hospital has a proprietary interest in the pre-Psychotic and delinquent child. The Child Guidance patient becomes the mental case of tomorrow. The patients who will be received by the Mental Hospital 10, 15, 20 years hence are in the schools, and many of them showing behaviour abnormalities that stamp them as potential Psychotics. It seems that the Mental Hospital has a grave responsibility in this field of prevention and must prepare to assume that duty as quickly as personnel can be secured and trained to do the work.

The stress laid upon work with children is entirely justifiable when one considers that prevention is most hopeful in childhood. It is the golden age for Mental Hygiene. The Child Guidance Clinic will be the important phase of preventive psychiatry. It will take many years to plough the ground and prepare it for the seed. Even administrative Medical Officers will probably look on this extension of clinical facilities with a jaundiced eye. The preparation must be a period of organization and education. The average man has little understanding of this kind of work with children. He is apt to think that a Child Guidance Clinic is interested only in feeble-minded or psychotic individuals. These Clinics should in due course form a part of the Pediatric Department of every General Hospital.

In spite of considerable progress towards a more healthy attitude in regard to Mental Disease, the old ideas of disgrace and stigma die hard, and the prejudice of the people must be taken into account. The relationship of Psychiatry and the Law requires attention. If the Mental Hospital is to do good work it must have the sympathy and support of the community. The walls of ignorance, superstition and suspicion will have to be torn down and a friendly relationship established. We must teach the people that we will staff our hospitals correctly, and that Mental Hospitals are directed by honest well-trained scientific men who are trying to render service to the patients. Good-will towards Mental Hospitals must be created. The process will be long, but may be built by :

- (1) Letting the community know that the Mental Hospital has a real service to be given.
- (2) Convincing people that they need what it has to offer.
- (3) Making it easily obtainable.
- (4) Making people glad that they can have what the institution has to offer.

The goal of such educational effort should be more than to add to the prestige of the hospital. The ultimate purpose should be Mental Health. This is the day of Preventive Medicine. Psychiatry should be thinking in terms of prevention as well as cure.

I am appending to this Report copies of the undermentioned, which I forwarded some time ago to every administrative Medical Officer in India. I find they are being seriously considered, and I would suggest that they be carefully examined by the Committee.

- \* (1) The Interim Report on the Recommendations regarding the Mental Health Service by the Royal Medico-Psychological Association.
- \* (2) Recommendations regarding the Future of Psychiatry by the British Medical Association.
- \* (3) The Royal Medico-Psychological Association Revised Recommendations.

#### SUMMARY.

The majority of the Mental Hospitals in India are quite out of date, and are designed for detention and safe custody without regard to curative treatment. The worst of them—the Punjab Mental Hospital, the Thana Mental Hospital, the Agra Mental Hospital, and the Nagpur Mental Hospital savour of the Workhouse and the Prison, and should be rebuilt. The remainder should be improved and modernized in accordance with the suggestions of the Medical Superintendents. Bombay and Calcutta urgently

require modern Mental Hospitals to meet both the needs of the community and the Medical Colleges, and these should form part of any schemes for reconstruction or expansion. The Superintendent of the Indian Mental Hospital, Ranchi, has put forward schemes for expansion, but this hospital is quite large enough for any single Psychiatric Unit, and it is too far from Calcutta to be of service in any teaching programme.

There is gross inadequacy in the medical personnel in all the Mental Hospitals both numerically and in specialised qualification. Most of the Medical Officers employed as Superintendents and Deputy Superintendents possess neither the status nor the experience which would justify the description of Consultant or Specialist in the ordinary usage of that word. A Mental Health Service is necessary with improvement in the status, pay, and conditions of service of the Medical Staff, with increased opportunities for purely professional work.

To remedy these defects foreign assistance will be required for at least ten years. Generous terms should be offered to highly qualified Specialists to take charge of Mental Hospitals, the teaching programmes, and to organize the Social Services during the transition period. Selected graduates (as many as possible) after a period of residence in a Mental Hospital in India should be sent to the U. K. or the U. S. A. for Post-Graduate training in Psychological Medicine. For some time, subordinate Medical Officers might be encouraged to obtain the Medico-Psychological Certificate, granted by the Royal Medico-Psychological Association.

The numerical and professional inadequacy of the Nursing staff and Attendants requires urgent attention. There is no reason why administrative Medical Officers should not tackle this problem immediately. The Indian Division of the Royal Medico-Psychological Association would be prepared to assist.

Psychiatry developed as the method of treatment of those individuals whose mental illness necessitated segregation from the rest of society. This distinction, although important socially, is medically irrelevant, for there is only a difference of degree between the majority of patients in Mental Hospitals and the far more numerous sufferers from less severe mental disorders. For one case of major mental illness there are, undoubtedly, many cases of minor mental illness. Preventive Psychiatry, therefore, outside the Mental Hospital is of paramount importance. To open Psychiatric clinics in General Hospitals before there is trained personnel to conduct them would be bad propaganda. In the U. K. modern developments in Mental Health Services are doing much to lessen fears and prejudices among the public, but they are still a factor to be reckoned with, and in India the greatest caution will be necessary. The movement to open Psychiatric Departments in General Hospitals in the U.K. and U.S.A. has coincided with the development of methods of treatment, which have made it possible to treat successfully as out-patients many who would formerly have required inpatient treatment. Events have thus lent their support to the movement to emphasize the links between Psychiatry and General Medicine to the advantage of both. It is vital that in any future organization of Medicine, Psychiatry shall not remain segregated, and it should take its place in the general scheme, subject to the provision of adequate and well trained personnel.

The few Psychiatric Clinics which have been opened in connection with General Hospitals in India are of the make-shift variety, and the facilities for diagnosis and treatment are not satisfactory. Where the Mental Hospitals are accessible it may be desirable to set up consulting centres under their own roofs. This experiment has proved successful in the Bangalore Mental Hospital and for Service Patients at the European Mental Hospital, Ranchi. Whatever steps are taken with regard to Psychiatric Clinics they will be adequate only if the arrangements allow Psychiatrists in Mental Hospitals to engage actively in out-patient work in the Psychiatric Departments of General Hospitals. The Senior Clinician in the Mental Hospital should hold the senior post in the Psychiatric Department of the General Hospital. Junior mental hospital doctors should be appointed as assistants in General Hospitals where they would take part in the work of the psychiatric out-patient department. If all hospital medical staffs were adequately remunerated, and if domiciliary work became a recognized part of the hospital service, it would become possible for an interchange between Psychiatric Staff of Mental and General Hospitals. Unless arrangements are made on these lines there is a danger that Psychiatrists on the Staffs of General Hospitals will ignore or be unaware of the opportunities offered by Mental Hospitals and the progress in therapy or research being made in them.

In the Memorandum submitted by me to the Health Survey and Development Committee in February 1944, I stressed the need for Central Control. This special arrangement for the coordination and direction of Psychiatric work is necessary because of the many intricacies of the subject, technical, sociological, and legal. Provincial Administrative Medical Officers, as a rule, have had no specialized training in Psychiatry, and if the Mental Health Services in the country are to be directed by them, the integration of Psychiatry into the whole medical structure, which is so desirable, will be frustrated.

The Director-General or the Principal Medical Officer of a National Health Service, who will be advising the Minister, will himself be advised by various senior officers concerned with clinical services, preventive medicine, etc., and it is at this level that a Directorate of Mental Health fits in. I have suggested that for the present the Superintendent of the Mental Hospital should advise the Provincial Administration on Mental Health problem, as the Mental Health Service develops there should be at the periphery administrative officers of Mental Health, who must have direct access to the Director of Mental Health at the Centre, as well as relations with Provincial authorities. In this way the Social and Preventive aspects of Psychiatry will be given full opportunities for development. Grants or subsidies should only be made to Provincial Authorities subject to adequate control and supervision from the Centre.

The cardinal points in the Indian Lunacy Act, 1912, have outlived their usefulness. Legal restraint has undoubtedly made the public reluctant to avail themselves of Mental Hospitals, and has militated against the early treatment of mental illness. Legal changes are imperative which will make provision for treatment of patients without the stigma of certification, but this is a subject outside the scope of this report. It might be suggested, however, that all private Mental Hospitals, Nursing Homes and pay-beds for mental patients should be brought under Government control and supervision.

Many patients of this category are being treated in Mental Hospitals and the arrangement is most unsatisfactory.

Legislation to deal with this very wide problem is urgent. This question is also outside the scope of this report, but any scheme will require the provision of suitable institutions and Colonies and it is suggested that in the Post-War period many suitable institutions will be available ; for instance the Military Camp at Ramgarh in Bihar would require little or no alteration to form a suitable Colony for 40,000 to 50,000 Mental Deficients. Doctors to be employed in such Colonies will, in addition to training in Psychiatry, require special training in Mental Deficiency.

A Mental Health Service should cover at least the Psychiatric requirements in Schools, Child Guidance Clinics, Psychiatric advice to approved schools, Borstal Institutions, Juvenile Jails, Remand Homes, Colonies of the Hostel type for delinquents and Psychopaths, but to formulate schemes will be the duty of the Directorate of Mental Health.

The public still regards the Mental Hospital, and all Services connected with Mental Health with unwarranted dread, and the Psychotherapist with doubt, derision, and awe. Education of the public must proceed *pari passu* with the development of the Mental Health Service.

Finally, I would stress that the conditions in some of the Mental Hospitals in India today are disgraceful, and have the makings of a major public scandal. It is suggested that a copy of this report be sent to every Administrative Medical Officer in India.

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and*

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## APPENDIX 22.

## MENTAL HOSPITALS IN INDIA WITH THEIR BED STRENGTH AND PLACE OF LOCATION.

<i>Provinces.</i>	<i>Location.</i>	<i>No. of beds.</i>	
1. Assam	.. Tezpur Mental Hospital, Assam ..	718	
2. Bengal	.. No mental hospital. Arrangements are made with the Bihar Government for the admission of mental cases in the European and Indian Mental Hospitals at Ranchi. There are number of private institutions for Lunatics.		
3. Bihar ..	.. European Mental Hospital, Ranchi .. .. Indian Mental Hospital, Ranchi ..	271 1,380	1,651
4. Bombay	.. Central Mental Hospital, Yeravda .. .. N. M. Mental Hospital, Thana .. .. Mental Hospital, Ahmedabad .. .. Mental Hospital, Ratnagiri .. .. Mental Hospital, Dharwar ..	1,227 390 267 176 199	2,259
5. C. P. & Berar	.. Mental Hospital, Nagpur ..	600	
6. Delhi ..	.. Nil.		
7. Madras	.. Mental Hospital, Madras .. .. Mental Hospital, Calicut .. .. Mental Hospital, Waltair ..	888 364 164	1,416
(Criminal lunatics are confined in the Mental Jail at Cuddalore).			
8. N. W. F. P.	.. Mental Barracks 2 in the Central prison, Peshawar, under separate staff ..	140	140
9. Orissa	.. Cases are sent to Bihar, Indian Mental Hospital, Kanke (Ranchi) where 60 beds are reserved for cases coming from Orissa.		
10. Punjab	.. Punjab Mental Hospital, Lahore ..		1,408
11. U. P. ..	.. Mental Hospital, Agra .. .. Mental Hospital, Bareilly .. .. Mental Hospital, Benares ..	617 408 331	1,356
12. Sind ..	.. Sir C. J. Mental Hospital, Hyderabad ..		343
<i>Indian State.</i>			
13. Mysore	.. Mysore Mental Hospital, Bangalore ..	300	300
Total bed accommodation			10,189

## APPENDIX 23.

STAFF AND ESTIMATES OF COST FOR THREE TYPES OF MENTAL INSTITUTIONS—  
*Recurrent Expenses of a Thousand-bed Mental Hospital.*

	Grade.	Monthly expenditure in Rupees.
1 Psychiatrist Superintendent ..	1,000—50—1,500	1,000
1 Psychiatrist Deputy Superintendent ..	750—50—1,000	750
18 Psychiatrists ..	350—25—650	6,300
8 Occupation Therapeutists ..	200—10—300	1,600
1 Psychologist ..	250—15—475	250
2 Psychiatric Social Workers ..	250—15—475	500
1 P. Assistant to Superintendent ..	300—15—525	300
1 Senior Matron ..	300—10—450	300
2 Junior Matrons ..	250—10—350	500
50 Nurses ..	125—5—200	6,250
500 Attendants ..	35—5—50	17,500
50 Menials ..	20—1—30	1,000
10 Clerks, Accountant, Storekeeper ..	100—5—200	1,000
1 Recorder Statistician ..	200—10—300	200
1 Head Cook ..	40—1—50	40
10 Cooks ..	30—1—40	300
15 Durwans, Peons, etc. ..	25—1—30	375
Food @ Rs. 25 per head ..	....	25,000
Medicines, Chemicals, etc. ..	....	2,500
Washerman, Barber, Darzi ..	....	1,000
Repair and Replacements of beddings, crockery, etc. ..	....	4,000
Occupation Therapy Material ..	....	5,000
Electricity, Telephone, coke for boiler, etc. ..	....	2,000
Maintenance of Grounds, Garden ..	....	1,000
Miscellaneous, including stamps, stationery, form, etc. ..	....	4,000
Total ..		82,665
Annual Recurring Expenditure ..		9,91,980
Annual per capita expenditure for 1,000 patients, say ..		1,000

The entire staff is to be provided with free unfurnished quarters.

There will be an outdoor psychiatric clinic and a child guidance clinic attached to the hospital and conducted by the staff.

Capital Expenditure on buildings, equipments, etc., will be approximately Rs. 10,00,000.

All pay mentioned above is consolidated and no special allowance is recommended.

**Recurrent Expenses of a Thousand-Bed Mental Deficiency Home.**

		Grade.	Monthly expenditure in Rupees.
1	Psychiatrist Superintendent .. ..	850—25—1,000	850
2	Psychiatrists .. ..	350—25—650	700
1	Physician-General .. ..	300—25—500	300
4	Psychiatric Social Workers .. ..	250—15—475	1,000
4	Psychologists .. ..	250—15—475	1,000
50	Trained Teachers .. ..	250—15—475	12,500
1	Personal Assistant to Superintendent ..	300—15—525	300
1	Senior Matron .. ..	300—10—450	300
2	Junior Matrons .. ..	250—10—350	500
25	Nurses .. ..	125—5—200	3,125
100	Ayals—female attendants .. ..	35—5—50	3,500
50	Menials .. ..	20—1—30	1,000
5	Clerks including accountant, storekeeper etc. .. ..	100—5—200	500
1	Recorder Statistician .. ..	200—10—300	200
1	Head Cook .. ..	40—1—50	40
10	Cooks .. ..	30—1—40	300
10	Darwans, pcons, etc. .. ..	25—1—30	250
	Food @ Rs. 20 per head .. ..	....	20,000
	Medicines, chemicals, etc. .. ..	....	1,000
	Washerman, Barber, Darzi, etc. .. ..	....	1,000
	Repair and Replacement of Beddings, Crockery, etc. .. ..	....	4,000
	Electricity, Telephone, Coke for Boiler, etc. .. ..	....	2,000
	Maintenance of Grounds, Gardens, etc. .. ..	....	1,000
	Miscellaneous including stamps, stationary, etc. .. ..	....	4,000
Total ..			59,365
Annual Recurring Expenses — $12 \times 59,365 =$			
Annual per capita expenditure for 1,000 patients = say			700
The entire staff is to be provided with free unfurnished quarters.			
Capital Expenditure on buildings, equipments, quarters for staff, etc., approximately =			
			10,00,000

**Recurrent Expenses of a Thousand-Bed Mental Home for senile and incurable cases.**

		Grade.	Monthly expenditure in Rupees.
1	Psychiatrist Superintendent .. ..	850—25—1,000	850
2	Resident Psychiatrist .. ..	350—25—650	350
2	General Physicians .. ..	300—25—500	600
1	Psychologist .. ..	250—15—475	250
1	Personal Attendant to Superintendent ..	300—15—525	300
1	Senior Matron .. ..	300—10—450	300
2	Junior Matrons .. ..	250—10—350	500
25	Nurses .. ..	125—5—200	3,125



*Recurrent Expenses of a Thousand-Bed Mental Home for senile and incurable cases.—(contd)*

				Grade.	Monthly expenditure in Rupees.
75	Male Attendants	..	..	35—5—50	2,825
75	Female Attendants or Ayahs	..	..	35—5—50	2,825
50	Menials	..	..	20—1—30	1,000
5	Clerks including accountant, store-keeper etc.	..	..	100—5—200	500
1	Recorder Statistician	..	..	200—10—300	200
1	Head Cook	..	..	40—1—50	40
10	Cooks	..	..	30—1—40	300
10	Durwans, Peons, etc.	..	..	25—1—30	250
	Food @ Rs. 20 per head	..	..	....	20,000
	Medicines, chemicals, etc.	..	..	....	1,000
	Washerman, Barber, Darzi, etc.	..	..	....	1,000
	Repair and Replacement of Beddings, crockery, etc.	..	..	....	4,000
	Electricity, Telephone, Coke for Boiler, etc.	..	..	....	2,000
	Maintenance of Grounds, Gardens, etc.	..	..	....	1,000
	Miscellaneous including forms, stamps, stationery, etc.	..	..	....	3,000
Total					45,815
Annual Recurring Expenses $12 \times 45,815$					5,49,780
Annual per capita expenditure for 1,000 patients—say					550
The entire staff is to be provided with free unfurnished quarters.					
Capital Expenditure on buildings, equipments, quarters for staff, etc., approximately =					10,00,000

## APPENDIX 24.

## \* REPORT ON TOWN AND VILLAGE PLANNING IN INDIA.

By

B. R. KAGAL.

## 1. INTRODUCTION.

1. The Government of India, in the Department of Education, Health and Lands, placed the services of the writer at the disposal of the Health Survey and Development Committee under the Chairmanship of Sir Joseph Bhore to advise the Committee on town and village planning. The Committee desired "to have a picture of what has been done and what should be done in the future in order to promote Town Planning as an integral part of the development of civil life on orderly lines in urban and rural areas." [The Secretary's (Health Survey and Development Committee) letter, 16-1/G of the 19th September 1944].

2. The tour, lasting two months, from the 9th October, 1944 to the 8th December, 1944 included the following towns and the adjoining rural areas :—

Delhi, Simla, Lahore, Karachi, Hyderabad (Sind), Ahmedabad, Baroda, Bombay, Poona, Kirkee, Bangalore, Madras, Hyderabad (Deccan), Nagpur, Jamshedpur, Calcutta, Patna and Cawnpore.

3. Before commencing the tour, a set of four questionnaires (Appendix II) was issued for eliciting available information. The names of the institutions and persons to whom the questionnaires were issued are at Appendix III.

4. The list of those who have given replies to the questionnaires is at Appendix V. Details of memoranda received in the course of the enquiry are at Appendix VI. The list of persons interviewed during the tour is at Appendix IV.

5. The terms of reference set out by the Health Survey and Development Committee in their letter dated the 19th September, 1944 were very wide. The writer had to determine the scope of the enquiry consistent with the time limit of two months prescribed for the purpose. The object, therefore, was to make a rapid survey of the points outlined in the questionnaires. The principles underlying the issues raised and the problems suggested in the questionnaires are in their turn based on the memorandum already submitted by the writer, in February 1944, to the Committee—attached herewith as Appendix I.

6. The memorandum deals with the recent advances in the science and practice of town-planning with special reference to the English practice and it forms the general background of this enquiry and the recommendations made in this report.

7. Apart from the disadvantages inherent in a rapid survey of this nature, the present abnormal war conditions have tended to exaggerate and distort the normal situation and present a confused picture. Effort has been made to make due allowance for these disturbing factors.

8. Town Planning, as it is understood at present, is a provincial responsibility. Senior officers of the Provincial Governments and States, whom the writer was able to contact in the course of the tour, showed a keen interest in the problem and generally expressed a desire to obtain a picture of the conditions prevailing in their respective areas. While this could not be done, in detail, an attempt has been made to deal more fully, Provincewise, with the

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\*The appendices referred to in this report have not been printed

special features which at once mark out one Province or State from the others. This, it is hoped, would make the report more useful to the individual Provinces concerned. It should, at the same time, give a fair idea to the Government of India not only of the measure of success or failure attained but also of the working that produced the results. The conclusions drawn in the body of the report are based on the material contained in the Appendices referring to the different Provinces and States.

9. The section on "A short History of Town Planning in India" attempts to make a general survey of the situation. The other sections deal with the main aspects of the subject, viz., Education, Legislation, Finance and Administration. Village planning, Location of Industry and Housing are dealt with in separate sections. The writer's suggestions for dealing with war structures are dealt with separately. In the body of the report as well as in the Appendices dealing with the Provinces and the States, the lines on which recommendations are to be made are indicated and the final recommendations, divided into two categories, one the short term and the other the long term are embodied in the last section.

## 2. A SHORT HISTORY OF TOWN PLANNING IN INDIA.

10. The history of town planning in India has been, and is, an unequal and continuous struggle. It began in 1912 with the "Battle of the Sites" on the question of the selection of a site for the location of the new capital near Delhi (Appendix IX). Unfortunately, this has been the only initial, though spectacular, success in "the battle of science and of faith in the future of the new Capital against association and sentiment". If the town planners of New Delhi have succeeded, it is not due to any weakness of the opposition but to the towering personalities of the experts and to the vision displayed by the then Viceroy and Governor-General (late Lord Hardinge) and the then Secretary of State for India, in supporting the town planners. Since then, the champions of town planning have consistently failed. Calcutta, Cawnpore and Madras have provided proof of these failures in the course of this rapid enquiry (Appendices XVII, XVIII and XIV). Indications of similar trends in other places are not wanting. Detailed enquiries in all the Provinces and States in this respect are likely to be helpful to the areas concerned so as to avoid earlier mistakes, if any, when their respective town planning departments are established and begin functioning.

11. The real danger, however, is not so much of active hostility (though this cannot be ruled out completely in the absence of strong and informed public opinion) as of a steady decline in and neglect of the initial high standard. This is exemplified by accretions like Shahdara in the suburbs of New Delhi (Appendix IX).

12. The Government of India did not restrict their interest to the adoption of the latest town planning principles in the layout and development of the new Capital area. They impressed upon the Provincial and State Governments the need for regulating and controlling the growth of their towns. The first report of the New Capital Town Planning Committee is dated the 13th June, 1912. The Government of India's letter to the Madras Government on the subject, in 1912, runs as follows:—

"The Government of India are of opinion that the question of town planning is one of great and growing importance. The great majority of large Indian towns and cities are surrounded by insanitary quarters which have been permitted to grow up without any sort of control and which are

often the starting grounds of plague and other diseases and a large population is crammed into an altogether inadequate space. There is also the growing tendency of suburban landlords to refuse to let agricultural land for building purposes and it is becoming more and more difficult to meet the increasing demand for land among large classes of the population for improved dwellings amidst more sanitary and healthy surroundings. The art of town planning is of comparatively modern growth, and it is only recently that town planning experts have arisen, in very small numbers even in Europe. The matter is therefore one in which progress must necessarily be slow, but the Government of India are of opinion that a beginning can be made by enquiries as to the necessity for town planning legislation and the form which such legislation should take."

13. The Government of India also indicated the main lines on which an Act might be drawn up. The suggestions were based mainly on the provisions of the English Housing and Town Planning Act of 1909. The Government of India further stated that the question of town planning, so far as it affected Indian cities and towns, needed examination from the following points of view :—

- (a) the extension of existing towns, and
- (b) the improvement and opening out of existing insanitary areas in old towns.

The Government of India opined that, where land on the outskirts of a town was mainly agricultural and could be acquired cheaply en bloc, the better policy would be for the local authority to purchase outright and secure a return by premium and ground rents as buildings extended, instead of depending on development taxes. But where an existing town had been allowed to grow up in a haphazard way with vested interests in the surroundings, the acquisition of land would of necessity be of a much more expensive and difficult character owing to delays in litigation and the rise in prices of land. It is in such cases that control would be preferable to acquisition, which indeed for financial reasons would, on a large scale, be impossible. The object of the suggestions made was to render it possible to control future urban development and to provide for the expansion of population without imposing increasing burden on the general revenues or the resources of local bodies such as were usually involved when urban land could be acquired only under the Land Acquisition Act.

14. Active interest in town planning became evident in the Provinces and States from about this time. Two of the leading town planners in England, Prof. Sir Patrick Geddes and Mr. H. V. Lanchester, were invited to visit India and advise their clients. The reports of these experts vary from the mere statement of a few of the local problems (for which no solution was suggested) to the submission of detailed schemes, plans and estimates according to the experts' terms of employment and length of stay in the province or State concerned. Some of the provinces, like the United Provinces, employed full-time consulting architects (a reference has been made to the Master Plan prepared by Mr. Lishman, Consulting Architect to the Government of the United Provinces in Appendix XVIII).

15. Prof. Sir Patrick Geddes and Mr. H. V. Lanchester, jointly and severally, advised, amongst others, the Provinces of Madras and the Central Provinces and Berar, and the States of Baroda, Gwalior and Indore. The Bombay University, in 1921, established a School of Sociology and offered its first Professorship to Prof. Sir Patrick Geddes.

16. By far the most interesting report, however, is that prepared by Mr. E. P. Richards, a noted English town planner, at the request of the Calcutta Improvement Trust. A separate reference has been made to it in Appendix XVII.

17. Since 1921, interest in the subject has steadily declined, except in the States of Hyderabad, Mysore and Baroda, and the Punjab in British India.

18. Three aspects of this initial progress and decline are striking ; these refer to the measures adopted by the Government of India and the States of Hyderabad and Mysore. The interest taken by the Government of India from time to time was an "occasional burst of insight" and not sustained, and so was the response. The initiative for the town planning movement was taken by the Government "from the top" instead of its coming "from below", as in the case of England (Appendix A of Appendix I) where the lead for reform in town and country planning was given by the public, the P. E. P. (Political and Economic Planning), the Town Planning Institute and the Royal Institute of British Architects. The Government accepted the lead and followed it up with necessary enquiries and legislation. In contrast, the Central and Provincial Governments in India have not taken adequate steps even to implement the recommendations made by the Holland Commission in 1918 (Appendix XX) on the scientific and technical aspects of town planning and by the Whitley Commission in 1930 (Appendix XIV) on town planning legislation. As a rule, the provincial Governments have not shown any active interest in the subject until recently when post-war problems came to the fore. In these circumstances, the decline was inevitable in British India.

19. The progress seen in Hyderabad, Mysore and Baroda can be traced to different reasons. The Government interest in these States has been sustained, though the means adopted to achieve the results have been different. Hyderabad and Baroda States sent scholars to study the theory and practice of the subject in England under town planning experts for a period of several years. These studies were not confined to flying visits of senior officials. The students on return to the State were given opportunities of training in order to study local conditions first and later they were given responsible positions as town planners. They received all the assistance they needed by way of necessary and adequate co-operation from the Public Health and other Government departments. The initiative, and later encouragement, on the part of the State, was thus assured.

20. In Mysore, on the other hand, the interest has been more "personal" than official, thanks to the initiative taken by the Ruler and the former Dewan, Sir Mirza Ismail. State students have not been encouraged by scholarships or by facilities provided by the Mysore University through the engineering college. Foreign experts have advised, from time to time, the State Officials on town planning, particularly with respect to Mysore and Bangalore, but the presence of these experts in the State does not seem to have benefited so far the Mysore engineers or the rural areas to any extent. There is thus the danger of this type of town planning deteriorating to the level of the present British Indian standards as soon as the experts leave the State. While the Mysore type of planning may be more spectacular, the Hyderabad type is more permanent.

### 3. TOWN PLANNING EDUCATION.

21. The lack of general education in town-planning through lessons on environment, health and hygiene in schools, of popular education promoted

by a technical society of town-planners or by municipalities and trusts, if only for reasons of enlightened self-interest, and of technical education through engineering colleges or architectural schools, is primarily responsible for the conditions obtaining in the country at present. General and popular education is no less important than the technical education. Without general education, public opinion, strong enough to influence the standards of municipal and improvement trust administration, can neither be expected nor created.

22. Post-war education would need a civic as well as an industrial bias for creating a balanced community.

23. The view held by some of our administrators that "The general principles of town planning are now fairly understood and it should be possible for the Town Planning Committee (of a municipality) to apply them in individual cases" (Appendix XIV) is not supported by English administrators.

24. Sir Gwilym Gibbon, C.B., C.B.E., D.Sc., Ex-Director of the Local Government Division of the Ministry of Health, England, a distinguished Civil Servant for half a century, in his book, "No. 2—Problems of Town and Country Planning" says :

"The need for research in town and country planning is at least as great as in any other field. The planner of today is much in the same position as the medical practitioner of some generations ago. His practice is largely empirical, with occasional bursts of insight. The body social is not less complex than the body physical and certainly not less difficult to understand."

25. If the above would apply to England, it would certainly apply with much greater force to Indian conditions. Research in housing and town planning forms an important part of the programme of the International Housing and Town Planning Congress as indicated in the appendices attached to Appendix I. The technical body for the promotion of town planning suggested in paragraph 28 should pay special attention to research.

26. There are no Degree or Diploma courses in town planning in the country. The subject is not taught in any of the engineering colleges. Ordinary facilities in the shape of technical books in college and university libraries are not available to students wishing to study the subject on their own. No enquiries for trained personnel are received by the principals of engineering colleges from Government departments, municipalities or improvement trusts.

27. Few of the public works, municipal or trust engineers, have the time or the opportunity to follow the town planning movement even in its literature, much less to know it, at first hand, from the success or blunders of other cities. But even accepting what can be done at a distance or even from a brief visit of an expert or advising officer, the real danger remains not that of streets, etc.—absurdly wrong perhaps—but of the low standard of the mass of civic and municipal art. From the confused growth of our past, we tend to be easily contented with any improvements ; this, however, will not long satisfy us, still less will it satisfy the next generation.

28. The benefit derived by the Hyderabad State by sending abroad students for town planning education and training has been indicated in Section 2 of the report and in Appendix XIX (on Town Planning & Indian States). The Government of India have a scheme under consideration to send students for training to Europe and America as a part of Post-War Planning. Some of these scholarships, commensurate with the importance of the subject, should

be earmarked for town planning. The Central Government should, as early as possible, call a conference of persons connected with the administration, science, practice and education of town planning, with the object of promoting the early establishment of town-planning courses in Universities and Architectural Schools and of creating a body, analogous to the Road Congress, to watch the interests of the Science of town planning in all its aspects.

#### 4. LEGISLATION.

30. The first reaction of several administrators, officers and public men to the suggestion that more energetic efforts are needed for slum clearance is that the existing legislative powers are inadequate and that in the existing conditions slum clearance and rehousing are beyond the financial capacity of local self-government administrations and of town planning and town improvement agencies.

31. All town-planning, town improvement and improvement trust legislation in India enacted after 1919 provides for :—

(a) the determination of the amount of compensation to be awarded for the land acquired on the basis of the *market value on the date of publication* of the notification for acquisition under Sec. 6 of the Land Acquisition Act, 1894 ;

(b) the market value of the land to be the market value *according to the use to which the land was put at the date with reference to which the market value is to be determined* ;

(c) powers to disregard increased value of land and buildings if it is specially high by reason of the use thereof in a manner which could be restrained by any court, or is contrary to law or public policy or is detrimental to the health of the inmates of the building or to the public health (Madras Town Planning Act, 1920) ;

(d) ampler powers by adding a separate schedule to the different acts, giving powers for further modifications in the Land Acquisition Act, 1894, which among others provide for privileges mentioned in (a), (b) and (c) above, and

(e) the recovery of betterment contribution from owners of properties improved by a trust scheme.

32. It is not possible to accept the suggestion that these powers are not ample, at any rate, to make a beginning. On the other hand, it is suggested by some of those who have carefully studied the Acts that these powers are far in advance of similar powers in English legislation at present. It is not within the scope of this report to examine in detail, the merits of the two extreme views ; the truth lies nearer the latter than the former. In the Punjab and in the Hyderabad State where full use is made of the existing powers, there is no complaint about the lack of powers. The Punjab claims that the existing legislation " gives reasonably wide planning powers ". The Hyderabad State planning authorities are satisfied that they have " practically all the powers needed for regional, town and village planning ". The actual working of the existing powers is, therefore, of greater importance for the purpose of this enquiry.

33. In the course of the enquiry it was disclosed that many of the officers responsible for the administration of the trusts or for tendering advice as valuers were not even aware of the nature of the existing powers. In no case were these powers being fully used, although they have existed for nearly a quarter of a century in some provinces.

34. Although legislation enacted prior to 1919 did not contain these special powers, there is nothing to show that any attempts have been made, either by the Bengal Government to seek these powers for the Calcutta Improvement Trust (1911), or by the Bombay Government to revise the now completely out-of-date Town Planning Act of 1915. A complete case for a Supplementary Act for town planning was made for Calcutta, as early as 1914 by Mr. E. P. Richards, at the request of the Chairman and Trustees for the Improvement of Calcutta (Appendix XVII) but no action seems to have been taken to implement the recommendations made in the report. What can be achieved even through the limited powers under the Bombay Act is, however, illustrated by the example of the Hubli Municipality (Appendix XIII). The municipal borough of Hubli, in the Bombay Presidency, was superseded by Government on the 5th January 1939 and it was handed over to a newly elected body on the 1st July 1944. The work done by the Executive Officer during the period of supersession of four and a half years (of which nearly four years are covered by the War) can be seen from the answers (Appendices VII & VIII) supplied to the questionnaires I and II.

35. It would thus appear that the trouble does not lie so much with the lack of powers as with the lack of the use of the existing powers, or lack of the desire to change them even when change has been recommended.

36. Housing legislation which mainly deals with subsidies for poor class housing is in a different category. No serious attempt has been made so far in India to deal with the housing problem either through state, municipal, cooperative or private agencies. The results of the cooperative housing movement in the provinces of Bombay and Madras have not been very encouraging. It is hoped that this question will no doubt receive simultaneous attention and further town and village planning legislation will include also housing legislation on the lines of the English precedent.

## 5. FINANCE.

37. Slum clearance and housing of the poor (who are not capable of paying an economic rent for the minimum accommodation they require for themselves and their families), involve financial considerations. It has been stated by most administrators that finance is the crux of the question and that slum clearance and housing have been held up for want of adequate State aid. According to the Chief Commissioner of Delhi, "The Government of India have proceeded on the principle that the Delhi Improvement Trust Schemes, in the aggregate, must be financially self-supporting." Timely action in preventing the creation of slums would no doubt be more economical in the long run. The loss in preventable deaths, in ill-health, suffering and consequent inefficiency cannot be measured in terms of money as also that from fatigue and lack of leisure with its consequent effect on the cultural activities of the people. The losses in man-hours in unnecessary travel to and from work through traffic jams in large cities have now come to be assessed fairly accurately.

38. All the above factors will have to be taken into consideration before the Government decide to continue their policy to ask the slum clearing and housing authorities to make their schemes self-supporting. Towns with their slums are man-made. The responsibility for creating and continuing them has to be shared by the Government, the industries and the public. If Local Self-Governments have failed, the Government's share in that failure due to errors of omission and commission cannot be entirely disowned. Benefits of industry are shared by the Government through taxation. It is an



admitted fact that most of the slums are a direct result of unplanned and uncontrolled industrial development. The unsuspecting and ignorant villager is drawn to the towns by the lure of employment and thus adds to the slum population.

39. Hospitals, T.B. sanatoria and preventive measures against smallpox, plague and other infectious diseases are not expected to be financially self-supporting. High personages connected with Government administration make frequent appeals for funds, and in fact secure them, for what are considered as deserving causes. These appeals, and philanthropists who readily respond to them, are rightly blessed by the community. But the root cause of all the disease and squalor, the slums, is allowed to multiply without Government accepting adequate responsibility for financing remedial and preventive measures.

40. All the benefits that free and compulsory education can bring to the child that is born and bred and later lives and dies in the slums would be of doubtful value. The effects of environs on the mind of the growing child are too well known to need emphasis. Any amount of education, however well-planned and costly, during the years six and fourteen, cannot compensate for the permanent harm done by environs. These tend to keep the individual "as mean as the street he lives in". This will have to be considered by the Government in apportioning the available finance between slum clearance and housing on the one hand and other nation building activities on the other. The responsibility for financing slum clearance and housing has been recognised by English legislation and accepted in practice. Beyond the rent-paying capacity of the worker, the financial responsibility for housing is apportioned between municipal taxation and Government subsidy. After their taxable capacity has been ascertained, Indian municipalities should be made to bear their full share in slum clearance schemes. Having done this, the Government would have to make their own contribution for making up the deficits.

41. At present the general practice is to allow *nazool* receipts to be set aside for town improvements. Legislation in order to reduce financial burdens to the minimum is necessary, where it does not exist, on the lines suggested in the preceding section. "But in addition to legislation, it is essential that there shall be a definite and progressive policy and, as a necessary corollary, funds to implement it" as has rightly been pointed out in the preface to the Report on the Re-organization of Urban Administration in the Central Provinces (1943).

#### 6. ADMINISTRATION.

42. Town planning is a social science in its purpose while its considerations of efficiency and costs are economic. In the matter of physical planning, both engineering and architectural problems come in. The objective is shaped and given the authority of the community and then administered through legislation and the governmental machinery which is broadly described as administration.

43. The efficient administration of such a complex phase of the community life of the people must necessarily be equally complex.

44. Judging from the present conditions in the country, dealing with this particular aspect of administration as revealed in the provinces dealt with in the appendices, the Governments appeared to be satisfied to "hold the ring to enable a multitude of rival individuals to advance their own interests and thus, by a beneficent alchemy, to promote the interests of civilisation".

Where results are to be obtained through the working of the Local Self-Government institutions, Governments will have to recognise the ineffectiveness of the passive supervisory, or at best exhortatory, role which the parent departments are at present used to assume. This will have to give place to a bold policy of forecasting, coordination and following up.

45. The Government of India, by setting up an elaborate machinery for post-war planning, have come to recognize that there is no peculiar " democratic " virtue in incompetent administration. Town planning should receive the right " priority " in the broadest sense. What is more, the public needs to be educated in formulating opinion on these priorities. Administrative organisations and methods will have to be adjusted to ensure the fullest and most rapid effect.

46. Financial and accountancy considerations which dominate a present, and the belief that administration is merely a regulatory, policing and taxing mechanism, will have to give place to the conception of Government as the nation's common instrument for ensuring the welfare of the community.

47. In the early stages of the development of town planning in England, the question as to which parent department should " bring up the baby " was settled by the traditional hit and miss method. First, the Ministry of Health and later the Ministry of Works were tried. But finally, a separate Ministry for Town and Country Planning has been established. It is not necessary that we, in India, need repeat the experiment. We might as well study the results of the experiment and avoid the now discarded intermediate steps by creating separate Ministries in the Provinces and establishing a corresponding organization at the Centre to provide the necessary coordination, expert advice and stimulus.

48. Issues and problems should be solved in proportion to their national importance ; when there is lack of coordination, they are solved rather in proportion to the strength of individual departments. The only method of securing action on a neglected subject, in the present conditions, is to create a new Ministry. Failing this, the neglect is bound to continue notwithstanding the best intentions.

49. If the Government of India take effective measures without any delay, both in respect of the short term and long term recommendations made in this report, it should be possible to synchronise the adjustment of the right relationship between the people, their work and their place with the raising of the standard of living through the National planning on a comprehensive scale.

50. The permanent civil servant cannot be blamed for the consequences where the advice tendered by him is not accepted by the Minister. But he will have to bear a fair share of the responsibility if his opinions and the technique for obtaining the information and for shaping and representing the policy prove ill-advised too often. It is here that he should share his responsibility with properly trained technical advisers. Given the knowledge and the will to do it, he is in a position to adopt, and alter where necessary, the techniques which the individual Minister is not in a position to do.

## 7. VILLAGE PLANNING.

51. The problem of the unearned increment accruing to the owner of the land near towns and industrial areas owing to urban development vitally affects village and country planning. Freedom to use such land for any

purpose without control of any kind either by the State or the local authorities further tends to promote usage of vacant land in a manner detrimental to the community.

52. A reference has been made to the Barlow Report on the distribution of the industrial population in the next section. Two other reports published in England of equal importance are the reports of the expert committee on Compensation and Betterment under the Chairmanship of Justice Uthwatt and the other of the committee on Land Utilisation in Rural Areas under the chairmanship of Lord Scott. Brief notes on these reports are at Appendices XXI and XXII.

53. The object of village planning can best be described in the terms that were referred to the Scott Committee for report. They are :—

“ To consider the conditions which should govern building and other constructional development in country areas consistent with the maintenance of agriculture, and in particular the factors affecting the location of industry, having regard to economic operation, part time and seasonal employment, the well-being of rural communities and the preservation of rural amenities. ”

54. Lord Scott and his committee rightly understood the direction to mean that the conditions to be imposed on constructional development in the countryside must be such as will be consistent with the maintenance of a *prosperous* and *progressive* agriculture, and that pre-war prevalence of malnutritional diseases must never again be allowed to recur.

55. In the course of the enquiry, the Scott Committee became convinced that there is an innate love of nature deeply implanted in the heart of man and that the “ drift from the land ” has been occasioned in large measure by economic inequalities between town and country rather than by any deep love of supposed urban joys. They agree with the views stated by Mr. G. M. Trevelyan : “ Today most of us are banished to the cities not without deleterious effects on imagination, inspiration and creative power. But some still live in the country, and some still come out on holidays to the country to drink in with the zest of a thirsty man the delights of natural beauty and return to the town re-invigorated in soul. ” In this natural desire to seek escape from the town back to nature and to the villages, preservation of the existing natural amenities of the countryside plays a very important part. It is quite distinct from the provision of amenities like a pure water supply, drainage, medical aid, markets and communications.

56. The technique of planning for villages is not different from that for towns. It has, however, to be modified according to the needs, characteristics, customs and standards of living. It is in this sphere that the knowledge of local conditions, customs and habits plays a very important part.

57. The location of the market place in relation to the village, of the manure pits, the cattle shed and grain-store in relation to the home are some of the problems that need special study and tactful handling. The principle of “ neighbourhood units ” adopted in the town can be worked into a village setting plan to enable one unit to serve several villages.

58. The house plan has to be adopted to the customs of the people and to the needs of the cottage industry existing in or suited to the community. Weavers, goldsmiths, ironsmiths, carpenters, washermen and petty shopkeepers have all their special needs ; a weaver needs large room or a covered verandah for his loom while an ironsmith or silversmith requires a well ventilated work room.

59. Town and village planning thus complement and are complemented by each other.

60. At present even less attention is being paid in the country to village planning than to town planning. The Government of India circulars to the Provinces and States in 1912 dealt only with town planning. Added emphasis on village planning is of a comparatively recent origin even in the Western countries which have advanced considerably in town planning. In England the necessary attention is being paid to this aspect only after the commencement of the present war.

61. Road planning and large scale electrification and irrigation projects would certainly help rural areas, but if planning principles are not simultaneously applied to the villages as well as to the towns at this juncture, there is a danger of more ultimate harm than good being done to the rural population. Multiplication of roads without adequate legislative provision against Ribbon development would prove disastrous. Even Ribbon development legislation might fail to produce the necessary results due to unsatisfactory dual control (*vide* para. 67 of the next section).

62. Colonisation schemes for the returned soldiers and for the educated unemployed are being planned and executed in the Hyderabad State. These and similar schemes for special groups could well form a marked feature of our future village planning.

63. Hydro-electric, irrigation and water supply schemes create problems of a different kind. Impounding reservoirs submerge existing villages and new areas brought under irrigation require new village sites. Temporary sites occupied by labour brought for the construction of dams, head works, and canals show a tendency to become permanent.

64. The Revenue Departments, Public Works Departments or the parent departments responsible for the major schemes have not so far paid much attention for planning for the rural areas and populations affected by their schemes. This kind of planning needs more goodwill, professional advice and coordination than money.

## 8. THE LOCATION OF INDUSTRY.

65. The Office of the Economic Adviser to the Government of India has recently prepared a Memorandum on "The Location of Industry in India". This Memorandum has two appendices; one is a summary of the majority report of the Royal Commission on the Distribution of the Industrial Population of Great Britain, and the other is a summary of the report prepared by the P. E. P. (Political and Economic Planning) on the same subject. The two appendices are relevant to this enquiry. Similar summaries of the two reports could have been produced in this report as appendices, but to avoid repetition, a reference to the Memorandum and appendices is invited.

66. There is, however, one important feature of the Royal Commission Report which needs emphasis. The Memorandum refers only to the majority report of the Royal Commission and not to the minority report. The minority report is signed by three Commissioners—Prof. Patrick Abercrombie, Mr. Herbert H. Elvin and Mrs. Harmoine Hiehens. Prof. Abercrombie has, in addition, added a Dissident Memorandum on "Planning in relation to the Location of Industry". While the Royal Commission unanimously accepted certain conclusions on the completion of the enquiry the recommendations in the majority report, in the opinion of Prof. Patrick Abercrombie and his

Other two colleagues, do not go far enough. Town planners would probably agree with Prof. Abercrombie for reasons given by him in his Dissident Memorandum.

67. The P. E. P. Report deals more fully with the relationship between the location of Industry and Town and Country Planning and this has a vital bearing on this enquiry. The Report had suggested the establishment of an Industrial Development Commission and in this connection it says :—

“ It has been pointed out already that the proposed Industrial Development Commission would not override in any way the zoning provisions and town and country planning schemes. The relationship between town and country planning and the control of Industrial location must, however, be rather more fully discussed, as considerable confusion exists over it, Parliament itself recently, through the Restriction of Ribbon Development Act, 1935, created serious fresh difficulties (wherever major roads are concerned) by requiring two different sets of authorities, working under different Acts and different Ministries, to deal with the same development proposals from much the same standpoint, but with different methods. It is clearly desirable both that this particular duplication should be corrected and that any fresh machinery brought into existence should provide for the smoothest possible cooperation and the clearest possible division of field between town and country planning and related activities.

“ The basis for separating the functions is clear enough. Town and Country Planning is essentially control of the use of the land. In any particular area it has to reconcile the claims of industrial, residential, and other uses in such a way as to secure the best pattern of development, taking into account both economy and amenities. It is vital to town and country planning that new industry of any type should not be permitted in the middle of a residential zone, but it is usually irrelevant to the town planner whether a proposed new industrial building is to be used for repairing motor cars or for manufacturing cigarettes. On the other hand, it is of no importance for the national guidance of location of industry whether a new factory at Coventry is in the middle of the town or on the east side or on the west ; the main consideration from this angle is what the factory is going to make, and whether it ought to be in the Coventry area at all.

“ There is no reason therefore to fear that the jurisdiction of an Industrial Development Commission would either duplicate or overlap with town and country planning, the Commission would simply fill what town planners have long recognised as an embarrassing gap, and the existence of such a body with a clear, long-range policy and mechanism for the guidance of industrial development nationally and regionally would be of great assistance to them, even in existing conditions” (pages 257 and 258 of the P. E. P. Report on the Location of Industry in Great Britain, March 1939).

68. The Government of India should no doubt take steps for controlling and directing the location of industries. Elaborate planning through the Planning and Development Department is already proceeding. At the same time action to promote Town and Village Planning with special reference to zoning provisions and to ensure coordination between the economic and physical aspects of the location of industry on the lines suggested by the P. E. P. in the preceding paragraph is equally urgent and important.

## 9. HOUSING.

69. Housing today is a study of human relationship in a balanced community. Reconditioning of houses also means reconditioning in every way the lives of their inhabitants. Sociologically, its greatest value is to be noticed in those areas which have not yet quite lost the halo of respectability but which, without outside help, are bound to lose it in the course of a few years. Its scope is certainly not restricted to the provision of a few colonies meant for the middle class population outside the towns like Bombay, Madras and Ahmedabad.

70. The present war has affected housing in many ways as it did during the last one. For the duration of the war, construction, except for war requirements, is restricted and controlled. The housing statistics in 1918 showed that, in that year, the total value of houses approved for construction by English local authorities was only 4% of that of 1913. In European countries there was similar fall in construction for residential purposes. In thirty five German towns, the number of new constructions fell during the period, from 45,000 to 1,172; in Vienna from 13,000 to 36. Towards the end of the last war, the housing industry in belligerent countries came almost to a standstill.

71. Indian housing has probably been so far affected in the present war as European housing was during the last war. Further deterioration in the situation is almost certain. Experience of the last war showed that the conditions further deteriorated after the armistice. The crisis was actually reached, in Europe, sometime between 1922 and 1923.

72. The return of the soldier with a new outlook on life, the reluctance of the agricultural worker to return to his pre-war job and the rapid changes in the joint family system which might necessitate millions of new households without any increase in the population are some of the problems that materially affect the supply of residential accommodation.

73. Rapid industrialisation after the war would be an additional strain at a time when, as the experience of the last war showed, the pressure on the housing accommodation would be at its worst.

74. No attempt is made in this report to describe the existing housing conditions in the rural, the urban and industrial areas. More detailed surveys are being made by the Health Survey and Development Committee through their special sub-committees and by the Labour Investigation Committee appointed by the Labour Department of the Government of India.

75. The Whitley Commission have described the conditions of industrial housing, in 1930, in the following terms :—

“ Neglect of sanitation is often evidenced by heaps of rotting garbage and pools of sewage, whilst the absence of latrines enhances the general pollution of air and soil. Houses, many without plinths, windows and adequate ventilation, usually consist of a single small room, the only opening being a door way often too low to enter without stooping. In order to secure some privacy, old kerosene tins and gunny bags are used to form screens which further restrict the entrance of light and air. In dwellings such as these, human beings are born, sleep and eat, live and die”. (Extract from chapter XV, pages 271-272, of the Whitley Commission Report).

76. Since 1930, the conditions appear to have steadily worsened. War work in industrial towns has no doubt contributed considerably to this worsening process. It is feared that it would worsen further, if judged by the experience of the last war.

77. The Whitley Commission held the view that the important causes contributing to the unsatisfactory situation were the lack of coordination between the employers, the local authorities and the Government, and the apparent doubt as to where the responsibility for the situation should lie. These causes still exist.

78. Stricter enforcement of municipal regulations would no doubt considerably improve environmental conditions. But these measures alone cannot reduce overcrowding, which is no less a health problem than lack of water supply and drainage.

79. There is no housing legislation in India. The English practice is to combine housing legislation with Town and Country Planning Legislation and it should be tried in India. Unless housing legislation with the provision for adequate State-aid is introduced in the Provinces and Indian States, no material improvement in the housing conditions can be expected.

80. State aid according to the English practice has been in the proportion of twice the financial aid the local bodies are asked to make to subsidise poor class housing. Help through tax exemptions is more common on the continent of Europe and in the U.S.A. In Belgium, for instance, all buildings built since 1928, the rateable value of which did not exceed a certain figure, are exempt for ten years from land tax. In the U. S. A., a ten year tax exemption was calculated to amount to a relief to the extent of 1/3 of the cost of the building.

81. The first effects of direct state subsidies in England were striking, but so became its later abuse. The relief did not normally reach the section of the community that needed it most. In the course of this enquiry also similar abuse was noticed in a case where State aided housing is being promoted. Aid, as given at present in England, generally takes the form of rent rebates to individual tenants, based on their capacity to pay and the area they occupy.

82. Cheap credit facilities and guarantees can alone enable local bodies to undertake housing responsibilities on a large scale. Cooperative Buildings Societies have failed to show satisfactory results in the Bombay Presidency. State-aided housing has also been tried in the Bombay but only on a very small scale, in the suburbs of Bombay.

83. The Government should follow a bold policy, and encourage Building Societies, promoting home-ownership and individual thrift, to be formed and registered. These provide a safe and easy way of saving, and an advantageous way of borrowing, for the economic classes able to meet their housing obligations. Insurance Companies would then interest themselves in helping the building societies in covering certain risks on the lives of the borrowing members.

84. Charitable Building Trusts for the benefits of the less fortunate members of the community are common amongst Parsees, Jains and Khojas in Bombay. These correspond to the Housing Societies in England. The Government and the local authorities should encourage such Trusts in every possible manner. Enquiries show that these trusts have so far received no help, let alone encouragement.

85. The housing of the villager in his village, as also in the town where he migrates as an industrial labourer, presents a special problem.

86. This type of labour is only casual to the town while it has its deep roots in the village. The habits of this type of worker should be made more hygienic but there is no reason why he should be denied the "atmosphere" of his native village even when he is working for industry. He is more "at home" in a bustee than in a chawl. He loves his front and back courtyard and would like to own his milch cattle if conditions permit. In effect he tries to reproduce his village conditions if he is given the opportunity. He can build his own hut with the kind of material which he has handled in the village. He yearns for his village chowpal (meeting place) and fondly remembers the pleasant nights he spent in bhajan, kirtan or folksongs with his village companions. He tries hard to remain unsophisticated, wedded to his rural culture.

87. Land is plentiful in India. With proper distribution of industry and control on land usage, it should be possible to keep down land values. If properly planned, India may never need to develop vertically for her residential requirements needed for the villager migrating to the town. It is cheaper to the state and to the local bodies to provide for the housing of this kind of worker. Attempts have been made on these lines in Jamshedpur, Madras and Nagpur with varying degrees of success. The experience of the working of over a quarter of a century is available and should be useful if carefully analysed.

88. The land intended for these "urban villages" should be levelled, laid with roads and drained. Water supply through public hydrants and sanitary conveniences are to be provided only at certain points. Community centres, shops, schools and other public buildings are to be the only permanent buildings in these areas. For the rest, the vacant land should be divided into plots of suitable and varying sizes and leased out to the workers on well-considered terms. Conditions of transfer should ensure that the lease rights are not acquired by the local 'bania' in settlement of a debt. Standard plans of buildings should be supplied. Building material should be made available at the site through municipal or Government agency. The bulk of construction can then be left to the worker, but if he needs help, it can be supplied, like the material, at cost. If the worker so desires, the entire construction can be undertaken on his behalf, the payments being made by the worker in easy instalments. In such a scheme, the urge to own one's own house would be strong. If the worker is a temporary resident and only wants accommodation on a rental, it should be possible to provide it for him in municipal or state-owned buildings on some of the sites.

89. These buildings would be only of a semi-permanent nature, made from locally available material. Consequently they would be comparatively cheap. More than cheapness, they would have an important advantage which a permanent building does not possess. With the steep rise in the standard of living, which is the main object of our National planning, the popular ideas about housing requirements would change rapidly. The next generation would probably not care to live in the houses which the present one considers suitable and convenient. A semi-permanent building can more easily be discarded in such circumstances than a permanent one. May be, the next generation would like to have, and could afford, a water connection and a water-closet inside the house and the municipality can, by then, extend its services to meet the demand which it cannot possibly do at present.



90. Starting with the urban village, these methods can be extended by the District authorities to the rural areas, where the initiative can be left in an increasing measure to the villager who has more abiding interest in his home.

#### 10. WAR-TIME BUILDINGS.

91. Hundreds of crores of rupees must have been spent on buildings constructed for War needs. Some of them would probably be required for the future peace time needs of the Defence Department ; according to the normal practice, those not required would be sold by public auction after the war. This matter would affect town planning in several ways.

92. Many of the buildings in urban areas have been located on sites which formed the lungs of the areas or were intended for some other permanent use. The pace at which these buildings were planned and constructed left no time for well-thought-out plans and substantial construction. Also for want of the required building materials like steel and cement, buildings of semi-permanent type had to be erected and unseasoned local timber had to be substituted for the usual seasoned Burmah teak.

93. With all these disadvantages, it should be possible to save to the country crores of rupees, if the problem of disposing of the wartime buildings is systematically solved.

94. It has been suggested that a large number of these buildings have been constructed on behalf of His Majesty's Government who might insist upon the structures, when not required, being sold by auction to ensure the best scrap value in the open market. If so, it is for the Government of India to examine the possible disadvantages of such a policy and convey to His Majesty's Government their considered views.

95. In urban areas, where this type of construction has been on the largest scale, land values have risen considerably. Inflation and the tendency on the part of the investing public to go in for land, at a time when the Japanese danger on our eastern boundary was considered real, have both further tended to raise values of vacant land to absurdly high levels. Those who have bought lands at such high prices have not been able to derive any benefit out of the present demand for housing due to non-availability of building material or State control on what little is available. Their only hope therefore lies in waiting for the material to become cheap so that it may compensate for the high cost of the land and thus level up the total investment on the completed building.

96. After the War, it is not likely that prices of new building material will reach prewar levels, at any rate, for some considerable time. The only alternative for the speculative builders, therefore will lie in the second-hand material likely to be released from semi-permanent war structures. There is thus a real danger of a scramble for indiscriminate jerry building with the help of such material in the urban areas. This may lead to the creation of more slums unless the Government takes suitable precautions to prevent it.

97. Municipalities, Improvement Trusts and Government departments can, however, make use of the material available from the war structures for their poor class housing schemes. Such schemes, if properly planned and located, would ensure to the State the financial benefit which would otherwise go to the land speculator to the detriment of architectural propriety and building standards.

98. The scope for utilization of war structures in rural areas is much larger. Some of the areas laid with roads, services and electricity can well form the nuclei for locating new or dispersed industries. These serviced localities can also be used for sitting satellite towns, market places or villages depending on their size and situation. The material from dismantled buildings can be utilized by district municipalities or authorities on the same lines as those suggested for the urban areas. Longer use could be made of suitable buildings as they stand or with the necessary alterations because in rural areas there would not be the same urgency or need for clearing the sites as might be the case in congested towns.

99. The problem, though vast, is so important that it should be handled satisfactorily on the lines indicated above by a special technical section of the department for handling the work of the disposal of War contracts and War materials.

## 11. A SUMMARY OF RECOMMENDATIONS.

100. A summary of the recommendations made in the body of the report has been arranged in this section in two categories, one short term and the other long term. The first paragraphs (A) under each heading deals with the recommendations that can be given immediate effect, while those in the second (B) indicate the lines on which the long term policy of the Government should be based.

### EDUCATION.

101 (A). (a) A small conference of persons of officials and non-officials connected with the administration, technique, practice, education of town planning and Local Self-Government should be convened by the Government of India. The conference should be asked to report on :

(i) the introduction of town planning courses in the existing Architectural schools and Engineering colleges ;

(ii) the scope and length of the courses ;

(iii) the method of practical training ;

(iv) the centre or centres where such courses can be immediately introduced, having regard to the existing standard of technical knowledge, experience, and other facilities available to train students ;

(v) the best means of obtaining and making available in the country technical advice for immediate and short term requirements ;

(vi) such other matters as the Government of India may desire to refer.

(b) A body, analogous to the Road Congress, should be constituted to promote the science, technique, education and research in town planning.

(c) Institutions like the Gokhale School of Economics in Poona, which are carrying on civic surveys, should be encouraged financially and students should be sent to such institutions for training.

(d) Scholarships for studying town planning outside India, and " Guest " professorships should be instituted.

102 (B). (a) General education in all its stages, from the primary to the college stage should be given a civic bias.

(b) Creation of a strong civic sense in the public should form an important feature of the policy of the Government, municipalities, technical institutions, and scientific bodies, through publicity, exhibitions and museums.

(c) Chairs for sociology should be established in the Universities.

(d) Where such chairs exist, students should be encouraged to take up civic surveys, likely to be helpful to town planning, for their post-graduate work and thesis.

(e) Designs for important layouts and public buildings in the country should be obtained by open competitions, the selection being left to a panel of judges drawn from all parts of India.

#### LEGISLATION.

103 (A). (a) Full use should be made of existing legislation, while its defects, if any, must be carefully examined with the help of technical advisers.

(b) Obsolete Legislative Acts should be revised and brought up-to-date.

(c) Town planning, town improvement, and prevention of ribbon development legislation should be enacted where it does not exist.

(d) In drafting legislation, advice of town planners should be made available to the administrators and legislators.

(e) Improvement Trusts should be established where necessary, in areas which are allowed by the municipalities to deteriorate. But the creation of trusts must be preceded by comprehensive surveys, definite programmes and the fixation of suitable town planning and housing standards.

(f) Until a sufficient number of town planners of a suitable type to advise the individual provinces on important matters of legislation are available in the country, the Central Government should make available technical advice for those provinces and States that ask for it.

104 (B). (a) Housing legislation should be considered an immediate post-war problem of high priority.

(b) An expert committee of the Legislative Department of the Government of India should examine the provisions of the Land Acquisition Act of 1894 in the light of the present town planning needs; and amendments to the Act should be suitably made, instead of a multiplicity of piecemeal amendments to the town planning and town improvement Acts of the provinces concerned.

#### FINANCE.

105 (A). Slum clearance schemes cannot be expected to be financially self-supporting. The financial responsibility for these projects should be shared between the Government, the municipalities and the industries that benefit by the large congregation of populations in towns, on an equitable basis.

106 (B). Housing finance, like housing legislation, is an immediate post-war problem of high priority.

#### ADMINISTRATION.

107 (A). (a) At the Centre, a Town Planning Officer with a suitable designation and status, should be appointed to ensure the co-ordination between departments, to tender advice and to provide stimulus.

(b) Departments for Town and Village Planning should be created in the Provinces under a Minister.

(c) In the Provinces, the Ministers and the Administrators should be advised by a Provincial Town Planner who should have the status of a Chief Engineer of the Public Works Department.

(d) The Government control and direction of the Local Self-Government machinery should be more effective.

(e) There should be no hesitation, on purely civic grounds, in either mending or ending municipal inefficiency, obstruction and other objectionable features.

(f) In superseded municipalities, local officers should be directed to make out definite programmes to be carried out within specified periods.

(g) Model building bye-laws for local bodies should be drafted and circulated. Local bodies should be required to adopt and enforce them.

(h) Inter-departmental co-operation and co-ordination, either through a liaison Officer or any other machinery, is essential for the success of town planning schemes.

108 (B). (a) Corporation, Municipal and District Board legislation should be examined and revised where necessary to bring it in line with recognized and up-to-date town planning principles and practice.

(b) It should be made obligatory on municipalities notified by Govt. to have executive officers with statutory powers.

#### VILLAGE PLANNING.

109(A). (a) Problems of "unearned increments" in land values, and "marginal" development should be effectively controlled by stricter measures of preventive and directive planning.

(b) Co-ordination between Town Planning, Revenue, Agriculture and Industries Departments is vital. This co-ordination can best be effected through the Town Planning Department for the purpose of siting of new industries or the dispersal of existing ones.

(c) Ribbon development should be strictly controlled by one single authority.

(d) Inequalities between rural and urban amenities should be minimised.

(e) Existing rural amenities should be preserved.

(f) The layout of market places in relation to a group of smaller villages, as "neighbourhood units", new sites for villages submerged by hydro-electric projects or for new communities, and colonising virgin countryside brought under cultivation by irrigation projects have to be planned well ahead.

110(B). (a) Provinces should, through their experienced revenue officials or expert committees, examine the powers necessary to regulate the conversion of agricultural into building land in, or in the vicinity of, large towns. Land Revenue Acts will have to be revised substantially to co-ordinate the land revenue policy, village planning and the location of industry.

#### LOCATION OF INDUSTRY.

111. Location of industry is governed by economic, social and strategic considerations. The town planner is best suited to advise on the sociological aspects of this important problem. His services should be freely utilised in deciding the broad policy, on a national and regional basis; while the siting of individual industrial areas and factories should be the responsibility of the Town Planning Department.

### HOUSING.

112(A). (a) The recommendations contained in the Holland and Whitley Commission reports, as far as they refer to steps that can be implemented in a short term policy, should be given immediate effect.

(b) Cooperative and building societies and philanthropic building trusts should be encouraged by the Government and local bodies.

(c) Credit facilities should be given to cooperative societies on a liberal scale.

(d) 'Company' towns, like Jamshedpur and Batanagar, should be encouraged.

(e) Vertical development for housing should be avoided as far as possible.

(f) The best that is in village culture should be preserved even while providing for the housing of the villager employed in industry, as suggested in paragraph 86 of the report.

(g) Cheaper type of housing, both in the urban and rural areas, should be encouraged on the lines suggested in paragraphs 88 and 108 in the report.

113(B). (a) The recommendations contained in the Holland and Whitley Commission reports on housing and allied matters should be fully implemented.

(b) Recommendation made in this report under Legislation and Finance [paragraphs 104 (B) (a) and 106 (B)] may be seen.

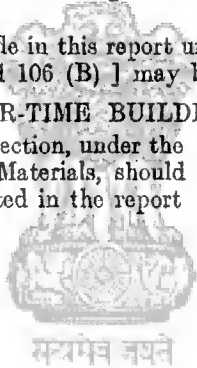
### WAR-TIME BUILDINGS.

114. A special technical section, under the Department for the Disposal of War Contracts and War Materials, should be created to deal with this question, on the lines suggested in the report (paragraph 99).

JAMSHEDPUR :

Dated 24-1-45.

B. R. KAGAL.



## APPENDIX 25.

*Functions of the Central and Provincial Water and Drainage Boards.*

## (a) The Central Water and Drainage Board.

The functions of the Board may broadly cover the following aspects of water and drainage problems :—

## 1. To lay down general principles to be adopted in respect of :—

- (a) investigation and preparation of water and drainage schemes in the provinces, including the minimum technical details to be gathered during such investigations ;
- (b) the order of priority in the investigation and execution of such works ;
- (c) the sources to be considered for water supplies ;
- (d) types of distribution systems to be adopted ;
- (e) nature and frequency of examinations for the control of quality of water supplied for public consumption, including the standards of quality to be maintained in water supplies of varying magnitude ;
- (f) standards to be aimed at in the maintenance of water works urban and rural, as regards mechanical equipment and plant control ;
- (g) the training and licensing of water operators ; and
- (h) plant control laboratories, including their equipment and staff.

2. To act as an information bureau for the supply of information regarding the latest developments in respect of water and drainage problems to provincial authorities and others interested in water and drainage problems.

3. To advise on the conservation of water and its distribution on an inter-provincial basis.

4. To advise on inter-provincial river pollution problems.

5. To promote research into special problems such as the presence of fluorides in water and the treatment of industrial waste.

6. To investigate sewage disposal and excreta disposal methods in so far as they affect the development of water supplies.

7. To recommend to the Central Government the sanctioning of grants from Central funds for water and drainage works in the provinces.

(b) The Provincial Water and Drainage Boards.

The functions of a Provincial Board will be mainly those enumerated above for the Central Board in so far as they apply to the province concerned. While the former will be independent of the Central Board, it is to be expected that the general principles laid down by the Central Board in regard to the development of water and drainage schemes will be followed in the provinces, as far as local circumstances permit, and that there will, in consequence, be a reasonable measure of co-ordination of provincial effort in these fields.

The Provincial Boards will be responsible for the active promotion of a planned development of water and drainage projects in their respective areas. The Central Board will perform the same functions in the Centrally Administered Areas.



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## APPENDIX 26.

*A note regarding the action taken in the Province of Madras to improve the administration of local bodies.*

The action taken in the Province of Madras to control the administration of local bodies in order to increase their efficiency may be considered under two heads, namely, (1) the period before the Public Health Act was enacted in 1939 and (2) the subsequent period. For both periods the administrative and legislative measures taken towards the attainment of the purpose in view will be considered together in this note.

Before the enactment of the Madras Public Health Act.

During this period the legal measures taken relate to the three Local Self-government Acts, the Madras City Municipal Act, the Madras District Municipalities Act and the Madras Local Boards Act, which regulate the administration of local bodies in municipalities and in non-municipal areas. These Acts were passed in 1920 a short time before the Reforms brought into being by the Government of India Act of 1919, came into operation in 1921.

(a) *Provincialisation of Health Officers.*—During the official years 1921-22 and 1922-23 the Provincial Government introduced a scheme of district health organisation for the rural areas in five districts and in the subsequent year extended it practically all over the Province. A District Health Officer with a Health (or Sanitary) Inspector under him for each taluk was appointed to work under the President of the District Board and the whole expenditure was met from provincial revenues. At that time a few of the larger municipalities had Health officers who were appointed by the municipal councils concerned as members of their establishment. In 1924 the Municipal Health Officers were also provincialised by the Government of Madras.

Under the Local Self-government Acts the right of appointing health officers had been vested in the local body concerned but the fact that Government bore the whole expenditure in respect of the district health organisation and three-fourths of the cost for municipal health officers helped to prevent opposition for the time being from the local bodies to this assumption of power by Government. A few years later, however, one municipal council decided to exercise its legal right to appoint its health officer although this decision entailed the forfeiture of the usual grant given by Government. To meet this situation the Provincial Government acquired in 1933 the statutory power to appoint health officers employed by municipal and non-municipal local authorities through suitable amendments to the respective sections in the Madras District Municipalities Act and the Madras Local Boards Act.

(b) In exercise of the rule-making powers conferred on the Provincial Government by certain section of the two Self-government Acts, Cholera Prevention and Control Rules were made for municipal and non-municipal areas by the Government of Madras in 1932. Under these rules the recommendations of Health Officer for additional staff and equipment during the prevalence of the disease or in the event of a threatened outbreak of it must be met by the local authority, any difference of opinion between the two being referred to the Director of Public Health for final decision.

(c) In regard to vaccination against smallpox all the three Acts provide that it shall be compulsory in rural and municipal areas "in respect of such persons and to such extent as may be prescribed". Taking advantage of this power and accepting that 'vaccination' includes revaccination, the Provincial



Government made, through the statutory rules which it framed, revaccination compulsory for all people living in rural and municipal areas at intervals of 10 years.

(d) Under the rule-making powers the Provincial Government prescribed from time to time the qualifications of the various classes of health staff that will be employed by local authorities.

(e) In order to improve the general administration of municipalities Government acquired power, in 1933, to appoint Commissioners by a suitable amendment of the District Municipalities Act. It was also provided that, when a Commissioner was appointed, he would replace the Chairman as the "Executive authority" of the municipality.

It must not be supposed that the appointment of Commissioners has so curtailed the powers of municipalities as to constitute a threat to local self-government. The Commissioner has only very limited powers as regards the incurring of expenditure without the sanction of the Municipal Council, but control over the municipal staff and routine administration have been transferred to him. The Chairman continues to convene the meetings of the Municipal Council and to preside over them. He is by virtue of his office a member of every Committee of the Council. Lastly it is obligatory on the Provincial Government to transfer the Commissioner if the Council passes, at a special meeting convened for the purpose, a resolution asking for such removal by a two-thirds majority vote.

It will be seen that, even before the Madras Public Health Act was passed the Provincial Government had taken action on fairly extensive lines to control local bodies in the fields of general and health administration.

Before the Public Health Act of 1939 the Director of Public Health had no statutory power to advise local authorities in respect of health matters while the health officers serving under Municipal Councils and District Boards had only advisory functions. The Public Health Act changed this position. The relevant sections are given in an appendix to this note. It will be seen from Section 6(1) that the powers of the Provincial Government for controlling local authorities are extensive and that Sub-section (2) of this Section enables the Government to transfer these powers to the Director of Public Health and the members of his staff. Under section 7 the Director of Public Health has the power to recommend for adoption by any local authority such measures as he may consider necessary for improving the public health administration in the local area or for safeguarding the public health therein and any difference of opinion that may arise owing to financial or other reasons will be referred to Government for final decision. Under section 13 the Director of Public Health has been given certain powers over the public health establishments maintained by local bodies.

Under Section 14 the health officer can exercise supervision and control over all the other members of the public health establishment of local bodies, although appointments, transfers and punishment are subject to the approval of the executive authority, which is in the case of a municipality the Commissioner and of a District Board, the President of the Board. In either case final decision rests with the Provincial Government.

Section 16 transfers the functions and the duties of the executive authority in respect of various provisions relating to health in a number of Acts to the health officer. Thus he is no longer merely an adviser. In matters such as prosecutions for the enforcement of law, he can act independently of the President of the District Board who is likely to be subject to local pressure.

Rules regarding notifiable infectious diseases which have been framed under the Madras Public Health Act and revised rules under the Municipal and Local Boards Acts in respect of cholera have strengthened the hands of the health officer for taking prompt and energetic action. The existing administrative and legal position has been succinctly stated by the Director of Public Health and his words are quoted below :—

“ The Madras Public Health Act confers powers on Government to appoint special Health Officers in the areas affected by or threatened with epidemics ; the Director of Public Health also possesses powers in connection with prevention and control of epidemics ; in addition to giving general directions to local bodies on the above subject, he may assign to any local area the public health personnel from other areas, Health Officers have powers under the Public Health Act to appoint additional staffs, concentrate in an area members of the staff from other places in their jurisdiction, purchase medicines and equipment, carry out disinfection measures, etc. The last of these powers is conferred on Health Inspectors also. When the Collector of the District notifies an area to be affected by or threatened with an epidemic of any of the notified diseases, of which cholera is one, the Health Officer gets additional powers, viz., control of movements of population and goods, disinfection, closure of markets, enforcement of inoculations and vaccinations and other kindred measures. It may also be stated in this connection that rules to supplement these measures have been framed in several instances by Government and these rules have the force of law.”

#### AN EXTRACT FROM THE MADRAS PUBLIC HEALTH ACT, 1939.

##### POWERS OF THE GOVERNMENT AND OF THE DIRECTOR OF PUBLIC HEALTH.

6. *Powers of the Government and of the Director of Public Health and his staff.*—(1) The Government shall have power to inspect, control and superintend the operations of local authorities under this Act.

(2) The Government may from time to time, define the powers to be exercised, and the duties to be performed, by the Director of Public Health or any member of his staff for the purposes of sub-section (1).

(3) Nothing contained in sub-sections (1) and (2) shall be deemed to effect, or derogate from, any powers possessed by the Government or the District Collector under any other law for the time being in force.

6-A. *Power of Government to direct performance by district board of any function devolving on panchayats.*—(1) The Government may, by notification direct that in respect of any function to be performed by a local authority under this Act and specified in the notification, the district board and not the panchayat shall be the local authority in all or any areas in the district which are comprised within the jurisdiction of a panchayat.

(2) Where a direction is issued under sub-section (1) in respect of any function, the Government may, by general or special order —

(a) determine, or provide for the determination of, the expenses incurred by the district board in performing such function in the area or areas comprised within the jurisdiction of any panchayat or panchayats, and

(b) apportion, or provide for the apportionment of, such expenses between the district board and the panchayat or panchayats concerned.

7. *Powers of the Director of Public Health to advise local authorities.*—The Director of Public Health may, from time to time as occasion requires, recommend for adoption, by any local authority, such measures as may be necessary for improving the public health administration in the local area, or for safeguarding the public health there in :

Provided that if on account of financial or other reasons, any local authority is unable to carry out such measures, or if there is any difference of opinion between the local authority and the Director, the matter shall be referred to the Government whose decision shall be final.

#### PUBLIC HEALTH ESTABLISHMENTS OF LOCAL AUTHORITIES.

8. *Public Health staff in local areas.*—(1) The public health establishment of every local authority (other than the Corporation of Madras) shall be on such scale as the Government may from time to time direct.

(2) The authorities who may make appointments to the public health establishments referred to in sub-section (1), the conditions of service of the members of such establishments, and the duties of such members shall, notwithstanding anything contained in the Madras District Municipalities Act, 1920, or the Madras Local Boards Act, 1920 be governed by regulations not inconsistent with this Act, made by the Government. Such regulations may lay down the extent to which the Director of Public Health shall have disciplinary control over the members of such public health establishments. (*Madras Act V of 1920. Madras Act XIV of 1920.*)

9. *Appointment of the Health Officer.*—(1) A local authority shall if so required by the Government include the post of a Health Officer in the establishment schedule.

(2) Notwithstanding anything contained in the Madras District Municipalities Act, 1920, or the Madras Local Boards Act, 1920, the Government—(*Madras Act V of 1920. Madras Act XIV of 1920.*)

(a) shall appoint the Health Officers of all the local authorities (other than the Corporation of Madras) in respect whereof a direction is issued under sub-section (1), and

(b) may recover from each such local authority, the whole or such proportion of the salary and allowances paid to the Health Officer, and such contribution towards his leave allowances, pension and provident fund as the Government may, by general or special order, determine.

10. *Appointment of temporary Health Officers in emergencies.*—(1) In the event of the prevalence or threatened outbreak of any infectious disease in any local area, or of any unusual mortality therein, the Government may, by order, appoint temporarily for such period as may be specified therein, one or more Additional Health officers, for the treatment of such infectious disease and preventing it from spreading, or for investigating the cause of and preventing, such mortality, as the case may be.

(2) For the purpose of sub-section (1) the Government may, appoint any medical practitioner registered under the Madras Medical Registration Act, 1914, either on an honorary basis or on such salary or allowances or both, as the Government may fix. The salary and allowances shall be payable from the funds of the local authority. (*Madras Act IV of 1920.*)

11. *Delegation of powers of Health Officer.*—The Government may, by general or special order, authorise any officer of the Government or of a local

authority, to exercise such of the powers of a Health Officer under this Act in such area, and subject to such restrictions, limitations and conditions and to such control and revision, as may be specified in such order.

**12. Appointment of persons to carry out the provisions of this Act.—**

(1) Notwithstanding anything contained in this Act or in any other Act or Acts governing the local authority or authorities concerned, the Government may, by general or special order, appoint any person or persons to carry out such provisions of this Act, and in such areas as may be specified in the order.

(2) The expenses incurred by such person or persons in doing so shall be met from the funds of the local authority or authorities concerned, either wholly or in part, and, where more than one local authority is concerned, in such proportions, as may be determined by the Government.

**13. Powers of Director of Public Health over public health staff of local authorities.—**(1) Subject to such rules as may be prescribed, including rules for consultation with the executive authorities concerned, the Director of Public Health shall have power :—

(a) to transfer any member of the public health establishment of a local authority to the public health establishment of another local authority; and

(b) in times of emergency, to assign one or more members of the public health establishment of one local authority for temporary duty in the area of another local authority.

(2) Nothing contained in clause (a) of sub-section (1) shall apply to the Corporation of Madras.

(3) In the case referred to in clause (b) of sub-section (1) the local authority within whose jurisdiction the member or members of the public health establishment of another local authority are working, shall pay for the period of such temporary duty, the salary and allowances of such member or members and such contribution towards their leave allowances, pension and provident fund as the Government may, by general or special order, determine.

**14. Health Officer's control over public health staff.—**(1) The Health Officer in charge of any local area shall exercise supervision and control over all other members of the public health establishment in such area.

(2) (a) Save as otherwise provided in this Chapter or in any rules or regulations made under it, all appointments, transfers and punishments of the members of the public health establishment under the supervision and control of the Health Officer shall be made by the Health Officer, subject to the approval of the executive authority.

(b) If for any reason the executive authority disagrees with the orders of the Health Officer under clause (a), the executive authority shall refer the matter to the Government whose decision shall be final.

**15. Local authority to provide adequate facilities to the Health Officer.—**Every local authority shall provide its Health Officer with such clerical assistance, office accommodation, furniture, equipment, stationery, and forms as may in the opinion of the Director of Public Health be necessary for the proper conduct of the business of such Health Officer.

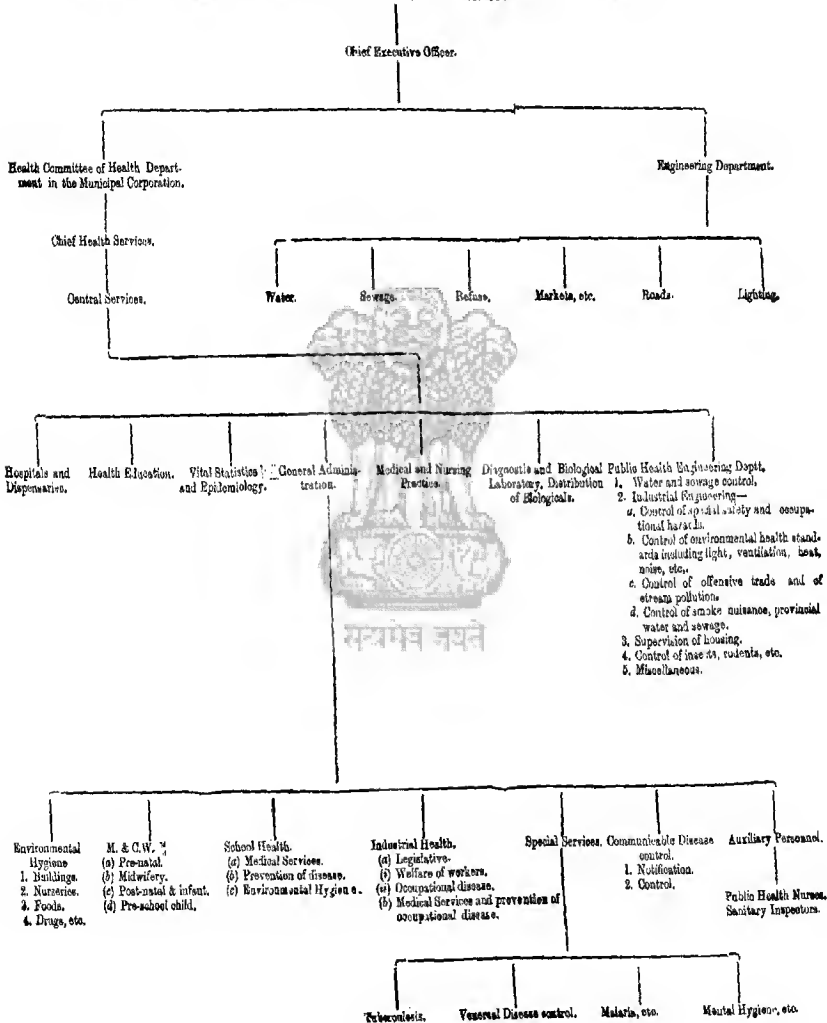
16. *Authorisation of Health Officer to perform the functions of the executive authority in public health matters.*—Notwithstanding anything contained in the Madras City Municipal Act, 1919, the Madras District Municipalities Act, 1920, the Madras Local Boards Act, 1920, the Madras Prevention of Adulteration Act, 1918, and the Places of Public Resort Act, 1888, the Health Officer of a local authority shall perform such of the functions, and discharge such of the duties, of its executive authority in regard to public health matters under any of the provisions applicable to such local authority contained in the Acts aforesaid, subject to such appeal and control as the Government may, by general or special order, determine. (*Madras Act IV of 1919. Madras Act V of 1920. Madras Act XIV of 1920. Madras Act III of 1918. Madras Act II of 1888.*)



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## APPENDIX 27

MODERN HEALTH ADMINISTRATION FOR A MUNICIPAL CORPORATION SUCH AS CALCUTTA, BOMBAY, ETC.



## APPENDIX 28.

**Memorandum on the training of "The Basic Doctor" and some problems relating to medical education.**

## PART I.

## I.—EDUCATIONAL PRINCIPLES.

The aim of medical education is to produce a body of medical men, capable of maximum service to the community. In most communities the doctor has been looked upon as an educated man whose opinion on problems other than those of medical interest carry a certain weight. The members of the medical profession, more than those of any other learned profession, come into contact with all types and grades of persons, from the most cultured to the unlettered and from those occupying the highest position in life to the commoner who with difficulty earns his daily wages. If he is to maintain that position which he has held in the past, it is essential that the medical man should have a high standard of general education and a broad outlook, professionally and otherwise, beyond the limitations of an examination syllabus, however well planned that may be.

The medical course, whatever its duration, will not permit of a student being taught more than a certain amount. This is particularly true in the clinical years during which it is impossible to attempt to provide the student with anything like the knowledge which he will require in his future professional career. Organised post-graduate education is therefore essential. The main emphasis in under-graduate teaching must be on the inculcation of principles and methods to enable the student to learn for himself and think, observe and draw correct inferences. It serves no useful purpose to impart to him a large number of facts most of which may become out of date. Provided a student is taught correct methods, he will continue to learn for the rest of his life, but if methods have been inadequately or incorrectly presented to him, his education is apt to cease on qualification.

There is another fundamental consideration which has not in the past been given due prominence. From the first, medical education must be carried out against a background of original investigation and research. Throughout his career the student must be made to realise that science and medicine are always progressing and that it is the duty of every medical man to try and make his contribution of original observations and new ideas.

Undergraduate medical education has in the past been concerned perhaps too much with the curative aspect of medicine. Preventive medicine must now come to the forefront and the duty of the medical profession should be largely to prevent rather than to cure disease. The promotion of health, the prevention of illness and the treatment of disease should all be dealt with in the curriculum, but greater emphasis must be placed on the first of these than has been the case in the past.

## II.—SUB-DIVISIONS OF MEDICAL EDUCATION.

These may be classified under the following progressive stages :

- (a) General education—at school or University.
- (b) Preliminary scientific education.
- (c) Pre-clinical scientific education.
- (d) Clinical education.
- (e) Medical Examinations.
- (f) Internship as House Surgeon or Physician.

(a) & (b) General Education and Preliminary Scientific Education.

The standard of general education required at present for entrance to a college of medicine in Indian Universities is the Inter-science, an examination conducted either by Universities or in some provinces by special Boards. The Inter-science qualification, if taken in Physics, Chemistry and Natural science—the medical group—enables the candidate to proceed immediately to the study of the medical subjects of the curriculum. In a few Universities, candidates pass the Inter-science with at least Physics and Chemistry as optional subjects and then undergo further training in Physics, Chemistry and Natural science for a period ranging from 6 months to 9 months (or one academic year).

It is a debatable question (a) whether the whole of the teaching of these fundamental sciences should be entrusted to Intermediate Colleges or (b) whether this instruction should also be given in Medical Colleges.

There are certain considerations which arise in this connection. These are :—

(1) Laboratory facilities at Intermediate Colleges in most Universities vary widely and the equipment of very few approaches the standards maintained in Medical Colleges.

(2) In many Universities a practical test is not held.

(3) The teaching of the subjects for the medical course should have a definite medical trend. This is difficult to ensure in Intermediate Colleges where future medical students are in a minority and the teachers are not in direct touch with medical needs. In Medical Colleges, the whole teaching is, or should be, directed to the medical students' requirements.

(4) The existence of these departments in a medical college and the close association of the professors with the pre-clinical and clinical professors are advantages from the point of view both of teaching and of research.

Three alternatives would therefore seem possible :

1. To allow students who pass the Inter-science in the medical group to join the medical course proper.

2. To let Inter-science candidates take a special course in the Preliminary sciences, ranging from 6 to 9 months, and then join the medical course proper.

3. To let these subjects be taught with the necessary vocational bias together with the pre-clinical sciences, i.e., (1) Applied Physics with Physiology (2) Biology with Anatomy and Physiology. (3) Organic and Physical Chemistry with Biochemistry.

Good arguments for and against these alternatives may be advanced.

Summary of Recommendations on Pre-medical Education.

(a) That the general education to be required from medical students should be improved ;

(b) That it is desirable that two years should be spent after the matriculation during which period the student should be taught the subjects of Physics, Chemistry (inorganic and organic) and Biology, besides English and the Elements of Statistics ;

(c) That the training should be such as to bring out the vocational bias as it relates to medical science ;

(d) That there should be an examination which includes a practical test ; the course and the test should be planned by a joint Committee of the Faculties of Science and Medicine ;



(e) That such training should be given by experienced senior teachers who have had opportunities of studying the requirements of the medical curriculum ;

(f) That with this end in view, detailed syllabi should be prepared in the different subjects, and

(g) If these requirements cannot be complied with, the student should after passing the Inter-science be given a special course of instruction for a period of six months, at the end of which he should be examined in these subjects by a written and a practical test.

(c) Pre-clinical Scientific Education.

The subjects of study at this period are :—

- (1) Anatomy including Embryology.
- (2) Physiology including Experimental Physiology and Bio-chemistry.
- (3) Pharmacology.
- (4) Elementary courses in Psychology and some of the clinical laboratory sciences.

(5) General Pathology and Micro Biology.

These courses cover a period of two academic years (or six terms at present).

There has been some criticism in regard to the training given to medical students in these subjects. The main points objected to are :—

(1) Too much detail is taught and is expected from the student, so that he becomes lost in a forest of detail and does not achieve a sound knowledge of fundamentals.

(2) The practical application of these subjects to his later studies is not brought home to the student.

(3) The transition from pre-clinical to clinical studies is too abrupt.

(4) The student in his clinical period of training does not have Applied Anatomy and Applied Physiology taught by his pre-clinical professors.

*Anatomy.*—The facts which medical students are required to remember should be reduced to a minimum. Anatomy, it has been stated, should be taught from the point of view of evolution and in relation to function, so as to give the student a concept of the structure of the body as a whole. Every student should dissect the whole body once but, having seen all the necessary details of structure, he should not be expected to memorise more than is necessary. Anatomical detail which is required for special surgical purposes should be stressed later during the clinical period, and memorised in conjunction with its practical surgical application. The department of Anatomy should be organised in the closest association with the teaching hospital and should be readily accessible to clinical students for reference concerning anatomical problems arising in their work.

*Supply of bodies for dissection.*—There is considerable apprehension among teachers of Anatomy regarding a possible insufficiency in the supply of bodies for the teaching of Anatomy and Operative Surgery. This is a matter which requires careful consideration by the authorities concerned.

*Physiology.*—This should take up the greater part of the time of the student in the Pre-clinical period. It would be well if Bio-chemistry were taught as one continuous subject by a chemist with a medical qualification who understands the relationship between Chemistry, Physiology and medicine and also if Bio-physics and Applied physics were taught with particular reference to the study of Physiology.

*Histology* is taught in some colleges in the department of Anatomy and in others in the department of Physiology. This is a matter best left to the decision of the Universities concerned.

*Pharmacology*.—This subject may be divided into two parts : one part to be taught in conjunction with Physiology and the other in conjunction with clinical medicine. The first part includes those drugs with a known and demonstrable physiological action on experimental animals. The second part comprises those drugs which have an action which is only understood by observing their effect on patients or which are used as chemotherapeutic agents in the treatment of disease.

In some colleges, Pharmacology is taught in the second year of the medical course, while in others it is taught in the third year after the candidate has passed in Physiology. If the subject can be taught in two stages, the first part should be included with Experimental Physiology, and the second part, Applied Pharmacology, with Therapeutics in the clinical period. The physician should work in close relation with the pharmacologist.

*Psychology*.—An elementary course is to be given in this subject so that the student's attention may be directed to the importance of the mind as well as the body. At a later stage this knowledge will be applied, in Psychiatry, to mental disorders. Coordination is required between Psychology, Psychiatry and Clinical Medicine.

*Methods of clinical examination*.—It is laid down in the existing regulation that elementary methods of clinical examination, including the interpretation of physical signs, the use of the stethoscope and ophthalmoscope, and introduction to general Pathology and Bacteriology should be taught in the pre-clinical period. It has hitherto not been possible in most Universities to arrange for this teaching up to the required standard.

*Number of students*.—Opinion varies considerably as to the optimum number of students at an institution. Some would have it at 60 while others hold that it should ordinarily not exceed 80 and only in exceptional instances reach 100 students per annum. It is the number of students that should determine the size of a teaching hospital and not *vice versa*. Additional beds required for the population should be arranged for in non-teaching hospitals.

The possibility of some students sitting for the B. Sc. in Physiology or Anatomy and thus gaining a fundamental degree in these subjects should not be lost sight of.

*Number of teachers required*.—Modern educational methods demand a high ratio of teachers to students. It may be stated that the proportion of teachers to teach in the subjects of Anatomy and Physiology should not be less than 1 to 10, and of these teachers at least half should be full-time members of the regular staff—i.e., not including demonstrators.

Besides these permanent teachers there should be part-time teachers, two for each of the departments of Anatomy and Physiology. These part-time teachers should be junior specialists attached to the surgical and medical units of the teaching hospital and they should give part of their time to teaching Anatomy and Physiology in their relation to the clinical subjects. There should be also a part-time radiologist attached, preferably with a diagnostic outfit at his disposal in the College.

The practice of employing, as part-time teachers in the pre-clinical subjects, men who at the same time hold part-time appointments of the 'Junior Specialist' or the 'Registrar' status in the hospital, has much to recommend it. Both clinical and pre-clinical work benefit from the liaison, and teachers themselves keep in touch with recent developments in the basic sciences. Such appointments, to be of maximum value, must give the holders reasonable opportunities for individual work, and should not be taken merely as a means of retaining a connection with the hospital or department. Appointments of this type should as a rule be held for a maximum period of three years.

*Hospital visits during pre-clinical training.*—Students undergoing training in Anatomy and Physiology should be required to visit the wards of a teaching hospital in small groups about once a fortnight during the second year. At these visits the part-time clinical teachers should demonstrate cases suitable for impressing the student with the value of a sound knowledge of Anatomy and Physiology and so stimulate his interest in those subjects. They should be shown cases of inflammation, fractures, hernia and similar conditions on the surgical side, while on the medical side cases of Jaundice, Anaemia, Arrhythmias of the heart, Hyperthyroidism, etc., will impress the student with the importance of Physiology. The examination of typical pathological fluids could also be done in order to stimulate the student's interest at an early stage in laboratory investigations.

*Length of course.*—At present the course extends over two academic years or six terms. Intermediate holidays badly interrupt proper teaching and the sustained interest that the student should take in his work. It should be possible to limit holidays, as is done during the clinical period of training.

*Staff.*—It is important that, if properly qualified members are to be recruited, the staff should be well paid and that there should be cadres established in the pre-clinical subjects. Demonstrators and clinicians may be part-time and may work their way up to become clinical specialists, but the senior members should devote their whole-time to teaching and research and should be adequately paid.

The importance of trained technicians in the departments engaged in pre-clinical education cannot be over emphasised.

Summary of recommendations on Pre-clinical subjects.

That the teaching of Anatomy requires revision in most Colleges and that the number of didactic lectures should be curtailed radically while the number of lecture demonstrations should be increased and preferably given to smaller classes ;

That dissection should cover the whole human body and should be under better supervision and guidance ;

That a considerable increase in the number of teachers is required if the subject is to be taught properly and within a shorter period than at present ;

That the number of permanent senior staff, Professors, Additional Professors, Assistant Professors or Senior Demonstrators should be 1 : 30 or 40, while the Junior Demonstrators should be 1 : 10 students in the Department ;

That a proportion of the Demonstrators should also be part-time clinical assistants in the hospital but these Demonstrators should work under the direction of the head of the Anatomy Department ;

That alternatively, if possible, a full-time teacher may be appointed as an Associate or Assistant Professor who will be a teacher of Anatomy with clinical duties in the hospital ;

That it is desirable to have cadres established for the pre-clinical subjects which will provide life careers for those electing ;

That the teachers and part-time teachers should be adequately paid and that full-time Professors of Anatomy should be paid on much the same scale as the full-time Professors in Clinical subjects ;

That there should be close cooperation and collaboration between the teachers of the various pre-clinical subjects, and between the teachers of pre-clinical and clinical subjects and preventive medicine ;

That it is necessary that opportunities should be available for students in the pre-clinical subjects and preventive medicine to be shown cases in the wards, and that demonstrations should be given to impress the student with the value that knowledge of these subjects will have for him later in his career.

That, with a view to make the student realise the importance of evolution, a study of comparative anatomy is desirable ;

That radiological demonstrations should be given to the student and that a diagnostic set should be fitted in the department ;

That if the fundamental improvements suggested above are carried out, namely, increased facilities and increased number of teachers, etc., it should be possible to teach Anatomy in 600 to 700 hours which should include the teaching of embryology ;

That in general the principles stated above regarding the teaching of Anatomy apply also to the teaching of Physiology ;

That the teachers in Physiology may be pure physiologist or physiologists with medical qualifications, but the principal qualification should be in Physiology with research experience in that speciality ;

That in Physiology, as in Anatomy, it is desirable to associate with the staff clinicians of at least the status of a Registrar, and these should be full-time teachers ;

That the subject of Histology may be taught in either the Department of Physiology or that of Anatomy, but the importance of the functional aspect should be stressed in teaching this subject ;

That Biochemistry may be taught in the Department of Physiology or may be established as a separate Department but the teaching of the subject to undergraduates should be undertaken in close cooperation with the Professor of Physiology ;

That applied Physiology should be taught in the clinical course either by a Professor of Physiology or by a Clinical Professor with special training in that subject ;

That the total number of hours devoted to the study of Physiology shall be 600 to 700 as in Anatomy, with 100 to 150 hours devoted to Biochemistry ;

That the Department of Physiology should be organised on a wider basis than merely the teaching of undergraduates, so that research and post-graduate teaching can form a fundamental part of the work of the Department ;

That it is desirable that special facilities should be made available for a medical student to qualify for a Degree in the pre-clinical subjects of Anatomy or Physiology ;

That a course of lectures in elementary Psychology and an introductory course of lectures in Pharmacology should be given towards the later half of pre-clinical training.

#### Clinical Education.

*Length of Course.*—This can best be decided by considering the length of time required to be devoted by the student to study and attendance at the different clinics. The facilities necessary for proper clinical training will be referred to in greater detail in a later chapter, but emphasis may at this stage be laid upon certain aspects of education which are not conducive to efficient training :

(i) Too many didactic lectures are being given in colleges, with little benefit to the student.

(ii) There is imperfect correlation in the teaching of Pathology, Bacteriology, Hygiene, Medicine and Surgery.

(iii) There is often repetition of the same theme, with possible divergences in methods of teaching and consequent waste of time and energy.

(iv) Clinical teaching is not considered as the prime duty of the staff in a teaching hospital, with the result that clinical teachers are overworked and have often neither the time nor the energy to devote even the necessary two hours a day to supervision of the students entrusted to their charge.

(v) The number of students posted under each clinical teacher is too large for effective personal attention and guidance.

(vi) The junior staff are not given the opportunities that they should have, to participate in clinical instruction ; nor are they always selected with this object in view.

(vii) In some medical colleges students are still required to spend an undue proportion of time in watching major operations. For most students this time could be spent more profitably in acquiring, under supervision, practical experience in those surgical procedures that are likely to fall to the lot of the general practitioner.

(viii) There is little or no coordination, and less planning, in clinical instruction, among the different clinical teachers of a department (medicine, surgery or obstetrics and gynaecology), so that the student who passed from one clinical teacher to another, not infrequently is treated to a repetition of the same theme, with little variation.

(ix) The proper selection of cases suitable for under-graduate teaching and the availability of such cases at the proper time, are matters that are hardly ever taken cognisance of in admitting cases to a teaching hospital. Cases of primary importance for the general practitioner are usually not available, and not infrequently the wards are filled with rare and complicated cases, the study of which, interesting as it doubtless is to the specialist, is not suited to the under-graduate.

(x) Teaching in the out-patient department in many institutions is entirely wanting, while overcrowded, insanitary, noisy and bustling surroundings such as at present exist, can never afford the atmosphere for proper clinical teaching.

(xi) The students have now to go from hospital to hospital to attend the specialities, with the result that much precious time is lost, and energy wasted. The specialities themselves are often taught without the fundamental background of medicine and surgery.

*Transition from Pre-clinical to clinical studies.*—In considering pre-clinical studies it was stated that the transition will be facilitated—

(a) By the students in Anatomy and Physiology being taught some portions of the subjects by part-time clinical teachers and conducted in batches through the wards of a teaching hospital.

(b) By an introductory course of lecture demonstrations in Elementary Pathology, Bacteriology, etc.

(c) By a special course of preliminary instruction given at the beginning of the clinical course.

We will now consider the nature and periods of instruction required for the different subjects of the clinical curriculum. No student should enter on these courses before he has qualified in the Pre-clinical subjects of study.

*Medicine.*—The course of instruction in Medicine may consist of :—

A. (i) Three months' preliminary instruction which will be common to Medicine and Surgery.

(ii) Six months' in-patient clerking.

(iii) Three months' out-patient clerking, and

(iv) Lecture demonstrations.

B. Courses of instruction in the other subjects of the clinical course which should be spread over a period of three academic years.

A. (i) *Preliminary instruction.*—This course should essentially be one in Applied Anatomy and Physiology combined with detailed instruction as to how to conduct the routine examination of a patient and to record the findings. There should be no distinction between 'medical' cases and 'surgical' cases, though one or other of these may be selected with advantage for illustrating specific symptoms and signs of disease. The course should be conducted jointly by the Heads of the Departments of Medicine, Surgery and Pathology.

At each session the whole group meets to discuss the principles and receive instruction, and is then divided into small groups of not more than 10 students, preferably less, who examine illustrative patients under the guidance of a junior member of the staff or a demonstrator. The organisation necessary to conduct such a course is considerable and necessitates a filing system in which patients suitable and accessible are recorded, as well as a knowledge of the material available in the hospital. The full educative value of such courses will not be utilized if there be not a sufficient number of suitable cases in the hospital. This can be remedied if the Heads of the Departments can call on the Assistants and Registrars of all wards to cooperate.

After the first six or eight weeks of the course each student should be allotted a few patients in the wards for full examination and recording, the patients being both 'surgical' and 'medical'. Stress should be placed at this stage on the accuracy of observation and of recording, and on the part played by laboratory and instrumental methods in obtaining accuracy and in amplifying the clinical examination.

A. (ii) *In-patient clerking.*—The six months allotted to in-patient clerking in medical wards should be divided into two periods of three months each.

(a) The first period of three months should be taken as soon as convenient after the preliminary instruction period. The student, should during this period, examine and record fully as many cases of different types of ill-health

and disease as can be under supervision, and follow their progress. He should not be required to examine and record more cases than he can investigate thoroughly. There must be no hurried work and what he does must be checked and supervised. He should accompany the physician on ward rounds and report the cases allotted to him. It is helpful if, during this period, he attends the out-patient along with the unit on days when the unit is responsible for admissions, so that he can see the new cases that are to be admitted and follow up the cases which may attend the out-patient of the unit concerned after discharge.

(b) The second period of in-patient clerking should be taken during the final year under the care of the professor and his associates or assistants. The cases should be selected largely for their value for teaching purposes or research. The number of students under each clinical lecturer should not exceed ten and the lecturer should be responsible for the examination and recording of all new cases and should conduct the teaching. He will, however, hand the group over to any member of the teaching staff who is specially interested in the system under discussion, such as the neurologist or the endocrinologist. It is very necessary to see that one of the students should present the case to his fellows in the group.

A. (iii) *Outpatient clerking*.—It has already been stated that when a student is clerking in the wards he should attend if possible the out-patient sessions to which the patients from his ward return for follow-up or continuation of treatment.

In addition to this he should spend 3 months in the general medical out-patient department. He should not, however, take any part in a crowded out-patient department where the physician is forced to do hurried and incomplete examinations. Such an example is bad for the student and encourages him to take shortcuts and resort to clever guessing. Every new case should have a complete history and physical examination and be fully recorded, and the student should be asked to take only such new cases as he can investigate thoroughly. He should then present the case briefly to the physician, who checks the findings and decides on disposal and treatment.

To enable the out-patient departments of most general hospitals to be used efficiently for teaching very drastic and far-reaching improvements are required. Hurried work, which is so bad an example to the beginner, is to be avoided.

A. (iv) *Lectures in medicine*.—At present students are given set lectures in the class room which are attended by them mostly for the sake of registering attendance. Too many theoretical lectures are given and not infrequently the time spent at these lectures could have been better spent at the bed-side in the wards.

In the Continental and American systems the University occupies a dominant position, the various departments being under the charge of a University Professor with a skilled full-time staff working under him. The professor instructs all the students in a particular subject and gives large-scale demonstrations at daily clinical lectures, accompanied by diagrams, specimens, etc. In Germany such departments under the control of professors are known as 'Kliniks'. Attached to each of these are lecture rooms, laboratories, rooms for students, etc.

It would appear that the best results are secured by combining the two systems, the Continental and American system of clinical lecture-demonstrations to large classes with the bed-side clinics and clinical clerking so much in vogue. The lectures in subjects like Medicine and Surgery should be given with a view to explaining certain fundamentals of each group of diseases and to giving a connected view of applied Anatomy, applied Physiology and Pathology and chief methods of clinical investigation and diagnosis together with methods of treatment of disease of the different systems. The student should then be in a position to study for himself the details in a suitable text-book. No Professor of Medicine or Surgery can deal with every known disease, or even the majority of such diseases, and it is futile to give a theoretical discourse on many of the diseases which are not commonly met with. The majority of the lectures should be illustrated with clinical cases; pathological specimens, radiological films, charts, etc., and these lectures should be carefully planned and prepared.

*Surgery.*—The teaching in Surgery should be planned on the same lines as that of Medicine. After the three months preliminary training, students should spend 6 months in clerking and 3 months in the out-patient department.

*Obstetrics and Gynaecology.*—The Obstetrics department should form a wing of the main teaching hospital, or a separate hospital for women and children may be built in the same campus and used for teaching purposes. It must detract from the value of the teaching and be a great waste of time if the student has to spend much time in travelling between hospitals. For the student's sake it is essential to have, in the main centre or very close to it, a department of obstetrics sufficiently large for the teaching of students. A bed strength of 100 for obstetrics and 50 for gynaecology may suffice for an annual intake of 70 students or thereabouts.

The period of clinical work should be not less than six months, three months of which should be spent in the final year and at least one month of this period should be spent in residence. The Indian Medical Council, like the General Medical Council, insists on each student personally conducting 20 cases of labour and this procedure has led to incorrect certification in both countries. According to this rigid standard, a student may conduct 20 cases of normal labour either in hospitals or in domiciliary practice, and not have witnessed a single case of abnormal labour.

It is more valuable for the student to spend his time in a hospital where he can only get 10 or 15 cases and yet see a large number of abnormalities than to conduct 20 deliveries in a district or maternity home and see no abnormal deliveries. Domiciliary practice is invaluable as this gives the student an insight into social medicine, but it is neither necessary nor profitable for him to spend a disproportionate period of time in attendance on cases in the district.

Attendance at an antenatal and postnatal out-patient clinic, clerking in ante-natal wards, attendance at Gynaecological out-patient clinic and wards and the follow up of the neonatal cases are of importance. The time devoted to obstetrics and gynaecology should be in the proportion 2 : 1.



There is a point of view frequently expressed that midwives and medical students should not be trained in the same hospital. There is a natural constant friction between the two as to who should take the case, but if a proper system of domiciliary conduct of cases be introduced for midwives to whom it is essential, and if a planned programme of case taking be arranged, there should be no room for complaint.

General practitioners who practice midwifery should have had post-graduate hospital experience. The average general practitioner does not want to do obstetrics, and if some form of group practice, as is envisaged, is evolved, it is likely that one man would do the whole of the obstetrical work of the group. Such a person should have obtained adequate post-graduate experience in obstetrics. The need for conducting 20 cases before graduation will probably be less in the future than hitherto, while more post-graduate work in obstetrics will be called for.

*Pathology.*—Pathology should be taught through all the years of the clinical period. This does not necessarily mean any increase in the time devoted to pathological teaching, but that it should be spaced so as to overlap with clinical instruction and not be relegated to a short period of intensive study.

There are two solutions to the question as to when an introductory course in Pathology should be given. i. That instruction in general Pathology and Bacteriology should be given before students enter the wards. ii. That instruction should begin co-incidentally with clinical studies.

It would appear that if students, during their pre-clinical studies, are familiarised with certain aspects of Pathology through conducted tours in the wards, the introductory course in Pathology would more profitably and suitably be given during the three months preliminary training at the commencement of clinical studies.

Included in the department, or associated with it, should be the four branches of Pathology viz., Bacteriology, Clinical Pathology, Morbid Histology and Chemical Pathology. The primary function of a pathological department in a medical college is the acquisition and dissemination of knowledge. The Pathology department being the key department in undergraduate and post-graduate teaching and in research, the professors or senior members should not be saddled with a great deal of routine duties and administrative work. Their work should be limited to that connected with research, while all routine work connected with other hospitals in the city or province should be done by a separate staff, who will, however, have the benefit of consulting the professors of the department.

*Correlation of the teaching of Medicine by pathologists and physicians.*—This presents difficulties and is not practicable over the whole fields of Medicine and Surgery, but in certain selected cases such a combined method of teaching would be of value. In public health there is scope for a wider collaboration in the teaching in Bacteriology and Immunology. In some important groups of diseases the system of combined lectures by the staff in Medicine, Pathology, Bacteriology and Preventive Medicine would be of great benefit, as a complete picture would be presented and unnecessary repetition avoided.

**Clinical Pathology.**—Clinical Pathology is a development of what used to be called 'test room work'. There should be for each medical unit a ward laboratory attached, while in the surgical units two units may share a laboratory room. These should be located in close proximity to the wards concerned so as to facilitate the work of the students. Besides these ward laboratories there should be a central clinical laboratory for the whole hospital in charge of the professor or a senior assistant where pathological, bacteriological and bio-chemical investigations will be carried out. This central laboratory, and the ward laboratories, should be under the supervision of the professor who should be responsible for running them efficiently.

There are two aspects of clinical pathology *viz.*, (1)—the teaching of the existence of tests as applied to the sick patients and all that such tests imply, and (2) the actual technique of the tests. The students should be taught to perform the simpler types of laboratory tests which they will have to carry out as general practitioners, but the actual technique of the more complicated or rarer tests need not be emphasised unless the students are intending to specialise later.

**Examination.**—Opinion is divided as to whether Pathology should come into the final examination, but the general trend of opinion is that it should be as near to the end of the student's course as possible. The view is held that, while Pathology should be allowed to play a large part in the training and qualification of students, it should remain with experienced clinicians to say whether a man is suitable to practice. If scientists, such as pathologists, come into the final examination it would magnify the importance of their subject. It has therefore been suggested that the examination in pathology proper should be held 6 months to one academic year before the final test. It is not suggested that the final examination will not include questions in Pathology or the examination of pathological specimens or slides, but such examinations should be in the hands of clinicians.

**Post-Mortems.**—This most valuable method of teaching Pathology requires greater attention in most colleges. Difficulties are no doubt increasing, but with effort and zeal more advantage should be taken of the opportunities to ascertain the pathological conditions which actually were the causes of death, and students afforded all facilities to attend at convenient hours. The post-mortem room should be so constructed that it will have all the advantages of a clinical lecture theatre and a side room laboratory should be available for demonstration of details.

**Public Health.**—This subject is of fundamental importance, for the future of medicine lies in the prevention of diseases and not only in their cure. Although it is laid down by the medical council that "Throughout the whole period of study the attention of the student should be directed by his teachers (a) to the importance of the measures by which normal health may be assessed and maintained, and (b) to the principles and practice of the prevention of Disease", little has been achieved in this respect. Few colleges here or elsewhere have a planned method of approach to tackle the problem. The importance of social medicine is even now but imperfectly realised. The follow up of cases is defective, the enquiry into environment hygiene is perfunctory and the follow up in the home to study conditions there with a view to arriving at more satisfactory conclusions in regard to the influence of home conditions on the causation or the prevention of diseases is hardly ever attempted. Too much theoretical presentation of the subject is attempted and too

little regard paid to the practical and applied aspects of preventive medicine.

The extensive administrative duties connected with public health will devolve on those with post-graduate qualifications in the subject. The general practitioner, however, has to deal with individual and family hygiene and home surroundings and the student should therefore be given opportunities during his clinical studies to familiarise himself with such condition. It would be well if he could for some period be attached to a Health Centre and avail himself of the opportunities to study home conditions.

This subject must be taught in its scientific aspects together with Pathology in the third and probably in the fourth year, while the applied aspect will be taught throughout the clinical years, more particularly in the fourth and final years. Teachers of Hygiene should be members of the Public Health Department who are actively engaged in Public Health work or who were till recently so engaged. If officials in the Public Health Department are seconded to a teaching post, they should be so seconded for a maximum period not exceeding five years.

#### SPECIAL DEPARTMENTS.

The student is at present required to attend the special departments of--

1. Ophthalmology.
2. Oto-Rhino-Laryngology.
3. Dermatology.
4. Venereology.
5. Psychiatry.
6. Infectious diseases.
7. Tuberculosis.
8. Orthopaedics.
9. Anaesthetics.
10. Radiology.
11. Vaccination.
12. Pediatrics.

The multiplicity of the specialities has led to a grave problem in undergraduate medical education. In many colleges these departments are located in special hospitals far away from the teaching centre and students have thus to expend much time and energy in journeys between hospitals.

Specialisation has certain advantages. It provides for more exact diagnosis of difficult cases and is better for treatment. In an undergraduate school a reasonable compromise between too little specialisation and too much is always required.

It is essential however that special departments should be developed within the main teaching centre. This will allow the student to see a large variety of cases and it should be a principle that members of the staff should be allowed to teach on cases not under their immediate care. Each medical school hospital should therefore have as many of these departments as possible, with a number of beds for all the specialities together equal to the number for general medicine and surgery. These beds will make it possible for groups of cases to be seen by the students in a relatively short time.

There has been a tendency of recent years for many physicians and surgeons to take up new branches of medicine and surgery and practice them exclusively. Neurology, Cardiology, Diabetes, Diseases of the chest, Urogenital surgery, Thoracic surgery, Neuro-surgery, Orthopaedic surgery, Fractures and Traumatic surgery are outstanding examples. This practice is tending to the formation of new special departments and has created a major problem in undergraduate medical education.

When a man of unusual ability and originality appears, another member of the staff with similar interest should be encouraged to work with him and the necessary departments should be provided for them. The departments should be adapted to the men rather than the men to an existing department.

This insistence that special departments should be located in the main teaching centre does not imply that special hospitals are not required. On the other hand, the existence of such special hospitals is desirable from the point of view of the speciality concerned as well as for purposes of post-graduate teaching. The opportunity afforded for a number of specialists to meet and exchange views in a special hospital is of great advantage. If such special hospitals are located in the same compound or in very close proximity to the main teaching hospital they would serve the three-fold purpose of affording facilities for—

- (a) Under-graduate teaching,
- (b) Post-graduate teaching, and
- (c) Opportunities for contact and consultation with the regular medical and surgical staff and other specialists.

A question of some importance is the place that these specialities shall hold in the examination of the undergraduate. Some of the specialities are now given prominence with a separate paper and viva-voce devoted to the speciality. Some share that honour with one or more specialities or find a place in the papers on medicine and surgery. In other cases it is open to the examiners to include a question on the speciality in the papers or clinicals in Medicine, or Surgery. The chief aim of the final test of the undergraduate should be to ascertain if he has a comprehensive view of the main subjects of Medicine, Surgery and Obstetrics and the inclusion of specialities, or even their possible inclusion, throws an extra strain on the student sometimes to the detriment of his general outlook. Two alternatives are thus available :

- (1) That knowledge of the specialities should be tested at the final examination either in the written, clinical or oral.
- (2) That the student should be required to pass an elementary examination in the speciality conducted by the teacher before proceeding to the final medical examination.

*Ophthalmology.*—It is essential that the student should be instructed in the diagnosis and treatment of injuries and the common disorders of the eye. He should be able to use the ophthalmoscope with sufficient skill to recognise the more important changes in the fundus due to general diseases. It should be possible to give this essential instruction in the ophthalmic department of a general teaching hospital in a three months' course, comprising clinical instruction and attendance at a course of lectures and demonstrations. In view of the importance of this subject, more particularly in

tropical countries, it would appear desirable that every student should be examined in ophthalmology before qualifying in medicine.

*Oto-Rhino-Laryngology.*—Training in this speciality should consist of instruction in the use of ordinary instruments and methods of examination so as to recognise the appearance of normal structures and to carry out simple tests of function. The period of clinical teaching should be three months, during which the student should attend the out-patient department, twice a week for two hours, and the wards or demonstrations once a week. A few systematic lectures may be given as a preliminary.

*Dermatology.*—There should be a department of Dermatology in every teaching hospital, which should consist of an out-patient department with adequate accommodation and a reasonable proportion of beds for the investigation and treatment of inpatients. Elementary instruction in the morphology, physiology and pathology of the skin should be given to students who should then attend a course of clinical instruction in the out-patient department and wards on one or two days during a period of 3 months.

*Venereology.*—Although this subject enters into the field of medicine, surgery, obstetrics and gynaecology and every other speciality, there is an advantage in the student attending a department of venereology, both out-patient and wards for special instruction in this subject.

*Psychiatry.*—This subject should be dealt with both in the preliminary course in the pre-clinical period and also in the clinical period. Apart from the special hospitals for mental diseases which obviously should be located at a distance, the main teaching centre should have an out-patient department and an observation ward for teaching purposes. A student should do three months clerking on psychiatric cases in the out-patient department with one attendance a week. A teacher should not handle more than 6 students at a clinic if students are to take an active part.

*Infectious diseases.*—At present the teaching of infectious diseases is very defective. The hospitals are poorly equipped and the staff in many cases are not selected from the point of view of teaching. The seasonal prevalence of certain infections makes it difficult for the student to study the different types with which he should be acquainted.

It has been suggested that a certain number of beds should be provided in every undergraduate teaching hospital both in the interests of patients and in the interests of teaching, so that a patient who develops an infectious fever while in a general hospital can continue his treatment in a fever ward of the same hospital without being transferred to a fever hospital. This can be done if the system of glass cabins in vogue in some continental clinics be introduced.

At present in this country cases of Typhoid and Puerperal fevers are treated in general hospitals and in wings of maternity hospitals although in Great Britain such cases are transferred to fever hospitals. There is now a changed outlook and it is realised that typhoid fever teaches a lesson in medical treatment and nursing technique almost unparalleled by any other disease.

If it is impracticable to implement these suggestions the only specialities that need be taught outside the teaching centre will be infectious diseases and mental diseases.

**Orthopaedics.**—The student should be introduced to the study of orthopaedic principles and practice immediately after passing the pre-clinical sciences, *i.e.*, during his first three months of preliminary instruction. At this stage with anatomical and physiological knowledge fresh in his mind he is well able to comprehend those principles which underlie the diagnosis and treatment of disabilities of the loco-motor system. The teaching should be given in the casualty out-patient department and in the orthopaedic ward.

The student should receive further clinical instruction in orthopaedics in the third and fourth years as a dresser. In the final year teaching should be provided in the orthopaedic out-patient clinics, and in fracture clinics, as part of the general out-patient teaching facilities. Seminars, ward classes and revision classes should also be arranged for small groups of senior students. It should be emphasised that an experienced clinical tutor is an essential member of the staff of all University orthopaedic teaching departments.

### *Radiology.*

(A) *Pre-clinical years.*—Radiological demonstrations on anatomical and physiological subjects should be more widely introduced and demonstrations should be given by members of the radiological staff when feasible, in collaboration with teachers in Anatomy and Physiology. It has been pointed out that one member of the radiological department should be recognised as a part-time teacher of the pre-clinical subjects. As few radiological departments can offer the space for large class demonstrations, medical schools should be equipped with appropriate apparatus which could also be used for research purposes.

(B) *Clinical years.*—The object of instruction during this period is to teach student the diagnostic and therapeutic value of radiology.

(C) *Radio-Diagnosis.*—1. Demonstrations as to how diagnostic radiology may help the student in his practice.

2. The X-ray appearance of lesions commonly encountered in hospital or general practice.

3. The rationale of, and preparation for, various X-ray investigations.

(D) *Radio therapy.*—Undergraduates should be instructed in (a) Types of cases in which radio-therapy is of value, and its contra indications.

(b) The implications of radio-therapy so far as the patient is concerned, *i.e.*, length and severity of treatment and reactions observed.

(c) The results obtained and possible sequelae. It is not necessary for the undergraduate student to be taught details of radio-therapeutic technique.

A few formal lectures should be arranged in order to explain the principles of radiotherapy and the biological reactions involved. These should be given in the final year, but there should be throughout the clinical course a close cooperation of the medical and surgical staff with the Radiological Department.

*Anaesthesia.*—This is a much neglected department in most teaching institutions. Students should be taught by a fully qualified anaesthetist and must have opportunities for administering anaesthetics under supervision. The appointment of 'clerk to the anaesthetist' should be held by every student during his surgical posting.

**Pediatrics.**—This subject as it concerns the older child should be taught in the children's department which every teaching hospital must have within its premises. The teaching of the physiology and pathology of neo-natal life should more properly be in the hands of a pediatrician in the obstetric wing of the hospital or in a separate maternity hospital in the compound. Special hospitals for children should be used for post-graduate teaching. Students should be posted for at least one month to the pediatric department when attached to the medical department.

**Tuberculosis.**—Every teaching hospital should maintain a tuberculosis dispensary and also a tuberculosis ward for the treatment of acute cases. Every student should be required to attend a three months course consisting of out-patient attendances and 15 or 20 clinical demonstrations in the wards. These demonstrations and such lectures as are given in this department should form part of the general teaching of medicine which every student is required to have. In this subject especially, clinical demonstrations are of far greater value than didactic lectures. The preventive aspect of this disease should be brought home to the student by domiciliary visits and demonstrations of the positive measures which are needed to limit the infection.

**Dentistry.**—It is not possible in all cases for Dental Schools to be run alongside medical schools. In some cases Dental Schools will have to be separate institutions, but in future planning it is well to take note of the fact that, both from the academic and financial points of view, it is logical for medical and dental education to be carried out in the same teaching centre.

In other centres, dental departments should be opened and the students should be given a short practical course in the subject and taught the importance of dental care in the maintenance of health.

#### **Forensic Medicine.**

The questions that arise are :

1. Is a separate course of Forensic Medicine necessary in the medical curriculum ?
2. If so, what should be its scope ?
3. At what stage of the curriculum should this instruction be given ?
4. Where and by whom should the instruction be given ?

A separate course in Forensic Medicine is definitely necessary, as without such a course, the student could not be instructed in the numerous medico-legal problems which will confront him when he enters general practice.

(i) *Duration and time when instruction should be given.*—A course not exceeding 40 lectures with demonstrations and medico-legal post-mortems may be given. It should be taught at a stage when the student has already obtained some instruction in medicine, surgery and obstetrics. It would not be wise to place it in the final year, for the final year should be devoted to the three main subjects. The best time is the penultimate year, the subject being covered within two terms of that year.

(ii) *By whom should it be taught ?*—There are three alternatives—

- (a) By a person specially appointed for the purpose.
- (b) By a police surgeon.
- (c) By a lecturer in the department of pathology.

The subject is certainly best taught by the police surgeon provided he is suitably qualified. The proper qualification is a good experience in the Department of Pathology (five years) with a higher qualification in that subject. Alternatively it may be taught in the Department of Pathology, but in such a case an assistant of the department should be specially trained for the purpose.

The undergraduate must have a grounding in Forensic Medicine. A faulty opinion in an ordinary medical case may be of some inconvenience to the patient but a faulty opinion in medico-legal matters may do permanent damage to a person's reputation and may endanger his liberty or even his life!

The present position in regard to the investigation of medico-legal problems is very unsatisfactory. Every medical practitioner in charge of a remote dispensary whatever his qualification or experience, is asked to undertake medico-legal post-mortems in complicated cases of crime and he is liable to be held in question thereafter. The presumption is that every medical man is competent to undertake these responsibilities, but unfortunately neither the profession, nor the Judiciary or the State have stopped to consider the absurdity of such a presumption.

Assuming the establishment of a State medical service in the future on the lines we have envisaged, a general practitioner attached to a health centre might take up medico-legal work to the extent of a minor speciality. The more complicated work should be undertaken by a specialist, or his advice should be available to the practitioner.

(iii) *An Institute of Forensic Medicine.*—There is need for a central Institute which will serve the triple purpose of—(a) Training specialists and teachers in Forensic Medicine; (b) carrying on research with particular reference to conditions in the Tropics and India; (c) to be a centre for expert advice.

Such a centre might well be located in a University centre, Bombay, Madras or Calcutta, or perhaps Delhi, if prospects of its early establishment are brighter there.

*Resident facilities for students.*—The advantages which will result from students residing in the hospital during a portion of their clinical course are becoming increasingly clear. At present, in many colleges, the student resides for at least one month during his period of training in obstetrics. Similarly it is imperative that he should spend at least a month while working in medical or surgical wards. The minimum period of residence should be three months, the maximum six months. This period of residence should be in the final year of study. During his stay the hospital should be responsible for providing the student with the necessary amenities, the student paying for his board only at reasonable rates.

It is important to see that separate common rooms and study rooms are provided, as otherwise the period of residence would not be utilised to the best advantage in studying and following the practice of the hospital.

If a period of six months residence is feasible the student may spend two months in the study of Practical Obstetrics; one month in Surgery; one month in Casualty work and Orthopaedics; one month in Medicine; one month in Pediatrics. During this period of residence, the student should



be encouraged to do responsible work, and he may be assigned 5 to 6 beds which he will look after under the supervision of a senior houseman or resident officer.

*The student's health.*—The clinical curriculum should be so planned that students can have at least one month's holiday, and preferably six weeks, every year. The health of the student should be the concern of the medical school which should provide routine clinical and X-ray examination of the chest once a year. Advice and treatment for medical students should be available from the experts of the medical school. Every teaching hospital should reserve a few beds, preferably in a separate ward, for the care of the sick under-graduate medical student. It ought to be impressed on authorities that this should not be considered a special favour, but that the managements of hospitals owe a moral obligation to students and nurses who come constantly in contact with diseased conditions, to provide hospital accommodation if they should need it, free and in separate cubicles.

Steps should also be taken to see that students are able to obtain good mid-day meals at a reasonable price in or near the medical school and that the school shall also contain adequate common rooms. All clinical students must be able to enjoy regular exercise in the open air.

*Post-academic residence.*—One of the urgent reforms needed is a compulsory House appointment for every medical student at the end of his course and as soon as he is qualified. At present the majority of students on their own initiative seek House appointments and nearly 70 to 80 per cent. of them are so posted. The period of compulsory post-academic residence should be twelve months and this should be after graduation, but before registration.

There are several ways of spending these twelve months, as, for example :—

1. 6 months in medical and 6 in surgical wards.
2. 4 months medical, 4 surgical and 4 obstetric wards.
3. 6 months in the main hospital in surgical or medical wards and the rest at a health centre, or special department, or hospital.
4. The rotating system of being posted every 3 months to different sections.

Whatever form of practice a student is going to adopt he should take a House appointment for a period of six months. The question of how he spends the second six months would depend on the branch of medicine he proposes to take up. There should not be any further examination at the end of the period of 12 months. A certificate of satisfactory work and conduct should be regarded as sufficient.

During this period every house surgeon should be in personal charge of at least 20, preferably 25 beds, and not more, but he should work under the supervision of a permanent member of the unit and under his guidance.

To ensure that every student passing out is posted as a House Surgeon, a survey should be made of the regional hospitals, and such of those as satisfy the standards should be included in the scheme. The University should be responsible for approving such hospitals and one of the clinical staff should, on behalf of the University, periodically inspect the hospitals which take residents.

During the compulsory period of House appointment, every House-man should be provided with proper residential facilities, and should be paid adequately for his services, so that he may be free from financial worries and devote all his time to the duties assigned to him.

The remuneration given for these appointments may take the form of (a) Free board and residence, free laundry, etc., with a pocket allowance, or (b) Free residence and an allowance ranging from Rs. 60 to Rs. 75 per mensem.

During this time a course of lectures on *medical ethics* and the conduct of practice might be given. The course should include instruction in the organisation of medical and social services available to the community and in the methods of using those services. Such a course would be of greater value at this stage than during a student's final year, when he is overwhelmed with work in preparing for the final examination.

*Summary of recommendations on clinical studies.*

That the Department of Preventive and Social Medicine should be organised on the same lines as the pre-clinical and clinical departments with centres of teaching and research facilities :

That this department should have control facilities (field work), i.e., facilities for the organisation and control of the rural and urban community fields attached to the department for demonstrating the principles and practice of preventive and social medicine.

That the staff should consist of the following :—

Urban.	Rural.	Hospital (College).
Professor Associate or Asst. Professor, 5 De- monstrators.	Professor Associate or Asstt. Professor, Sani- tary Engineer (F. T.), 12 M. O. H.	Professor, 9 Social Workers, 36 Case Workers.

The total being 23, with six senior teachers and exclusive of social workers. In a rural unit, not more than two students should be holding intern appointments in a primary unit.

That, at a very early stage, facilities and trained personnel should be made available to put into operation the scheme of training in preventive medicine which the Committee consider as essential for the training of the basic doctor. A copy of that scheme is given as appendix 29.

That, in the meantime, the preventive medicine aspect should be stressed in the teaching of every subject throughout the clinical course, and the student be given an insight into social medicine by contacts with home and community life.

That a note embodying these recommendations in regard to training in preventive medicine should be circulated to all medical institutions and Universities for information.

That a Hospital Social Service should be established as soon as trained personnel are available.

That an introductory course of instruction in elementary Psychology and Pathology should be given to the students by the Professors of the Departments concerned either in the latter half of the pre-clinical period or in the first three months of the clinical period. Methods of clinical diagnosis, including laboratory technique and the elements of nursing and dietetics with an introduction to social medicine, should be taught at the beginning of the clinical period.

That clinical records should be carefully written up and they should be preserved and these records should be under the charge of a responsible member of the staff.

That, in the teaching hospitals, clinical pathological conferences should be periodically convened at which all the members of the clinical and pathological staffs should be present. The senior students should also be present.

That, just as pre-clinical teaching should have a clinical bias, clinical teaching should be conducted with the scientific bias emphasised at every stage.

That the following should be the periods of clinical clerking and posting of students to wards, it being understood that proper emphasis is laid on out-patient training, especially in the junior stage :

Medical ..	..	3 months junior and 3 months senior.
Surgical ..	..	3 months junior and 3 months senior.
Obstetrics and Gynaecology, including Pediatrics ..	..	3 months junior and 3 months senior.
Specialities ..	..	9 months divided into periods of 3 months each for surgical, medical and social medicine.

(The above periods, added together, make a total of 27 months. Specialities may be attended daily for one month or for 2 days in a week for 3 months).

That the last three months should be available to the student to attend such clinics as he may feel inclined to.

(NOTE.—A view was expressed that 6 months is not sufficient for surgical and medical wards posting and the out-patient clinic should play a larger part.)

That this scheme can be brought into operation provided that the organisation of departments are on the lines suggested, and that well qualified and well trained teachers are available in sufficient numbers, so that there is a proportion of 1 : 8 junior teachers and 1 : 10 for senior teachers.

That every clinical teacher should emphasise the physiological aspects of his subject and should impress on the student the social and preventive aspects of medicine.

That there should be full-time professors in each of the subjects of Medicine, Surgery and Obstetrics with Gynaecology.

That, in the teaching of Obstetrics, special emphasis should be laid on the antenatal physiology of labour. The question of adequate training in Pediatrics should be further considered.

That domiciliary practice should be encouraged and that this should be particularly emphasised for women students.

That all students should be in residence for at least 3 months, one month being spent in each of the departments of Medicine, Surgery and Obstetrics.

That the number of beds in a unit should be at least 40, and that 8 or 10 students should be attached to each unit.

*Recommendations on Pathology.*

That there should be a well-organised department of Pathology in each teaching centre to include the departments of Morbid Anatomy, Micro-Biology (Bacteriology and Parasitology), Experimental Pathology and Clinical Pathology ;

That, in each institution, there should be a Board consisting of the Pathologist, Clinician, Physiologist and Anatomist, meeting at least once a term to coordinate the teaching of those subjects in the clinical period ;

That experimental Pathology should form an essential part of the work of the department, and that mammalian experiments should be demonstrated to the students ;

That the teaching of Micro-Biology, Bacteriology and Parasitology should be coordinated with the teaching of social medicine, and that there should be opportunities for demonstrations during field work ;

That, in the teaching of Morbid Anatomy, planned methods of teaching should be laid down in consultation with the Professors of Surgery and Medicine ;

That Pathology and Bacteriology should be taught throughout the period of clinical studies. About 600 hours are likely to be required, exclusive of the time spent at Autopsies ;

That the Physician and the Surgeon concerned should attend the post-mortem with the students, and should participate with the Pathologist in the discussion and exposition of the post-mortem findings in so far as these bear a relation to the clinical findings and diagnosis ;

That the staff should be whole time and should consist of :—

A full-time Professor ;

Three Assistant Professors, or Readers, of whom one will be for Clinical Pathology, and one for Micro-Biology ;

One or two Associate Professors, who should be either junior or senior Physicians or Surgeons, the idea being to associate also a junior or senior Obstetrician and Gynaecologist with the teaching.

That the Head of the Department of Pathology should be Ex-Officio Consulting Pathologist to the teaching hospital ;

That, in view of the importance of Autopsies in the training of the medical student, it was for consideration whether State legislation was necessary to make them obligatory when the physician or surgeon in charge of the case considered them to be necessary.

*Forensic Medicine.*—That Forensic Medicine should be taught by a person who should be a whole-time teacher and should have a sound knowledge of Pathology and also a post-graduate qualification in Pathology or Medicine.

*General Recommendations.*

That Clinical Clerking in Social Medicine should be performed in the afternoon in the 4th year while working in the specialities, and in two groups; the total number of hours being 100;

That Pharmacy may be taught in the earlier part of the clinical course;

That the second course in Pharmacology may be correlated with the lectures and clinical demonstrations in Medicine;

That Toxicology should be taught with forensic medicine;

That Therapeutics should be taught in the latter half of the clinical period;

That there should be a department of Pharmacology and Therapeutics together with experimental therapeutics;

That the staff of that department should include a whole-time Professor of Pharmacology and an Associate Professor of Therapeutics and assistants, one of whom should be a chemist;

That every teaching hospital should have at least one fully qualified pharmacist and that he should assist the department of pharmacy;

That it is desirable that, in the clinical professorial units, one of the assistants should be a trained pathologist and that he should be available for teaching, research and consultation;

That samples of blood, urine, faeces, smears, etc., should be examined in the side laboratories and that these laboratories should be equipped for this purpose;

That, as far as possible, autopsies should be done at a fixed time but, in cases where this is not possible, the pathological specimens collected from the post-mortem should be exhibited for 24 hours in a convenient place together with full clinical or pathological notes on the case;

That there should be a Museum under a full-time Director, containing a small and adequate number of specimens in each subject selected from the point of undergraduate teaching and with full notes available.

That the teaching of operative surgery and applied anatomy might be covered in 30 or 40 classes—(a series of window dissections is particularly useful for the study of Regional anatomy).

Opinion was divergent as to whether undergraduates should be given training in operative surgery on the cadaver, and whether an examination should be conducted on the dead body.

That it was extremely desirable that every medical student should be given adequate training in First Aid and Ambulance work in the pre-clinical period and that those who joined the U.T.C. should be exempted as it was considered that they would be sufficiently trained.

*(c) Medical Examinations.*

The system of examinations for the undergraduate who has entered on his regular medical studies deserves careful consideration. In a publication issued not long ago under the arresting title "An examination of examinations", by Sir Philip Hartog, it was made clear that, even in the valuation of the written script, there were wide variations between examiners, the variations ranging between 30 per cent. and 75 to 80 per cent. The possibility of such variations is not less in the conduct of clinical and viva-voce examinations. Well trained and seasoned examiners are an asset, but there is an advantage in gradually including fresh talent, so that the system of examination should not be petrified and static.

In a well regulated scheme, there should be internal and external examiners in equal proportion. This is not always possible in India, where long distances, time needed for examinations and the expenditure likely to be incurred may make it difficult. Examinations have, after all, a limited value, but the more important consideration is the provision of adequate facilities for teaching, competent staff with a liberal number of teachers and the provision of well equipped laboratories, a library and an adequate range and variety of cases. The conception which medical councils have apparently acted on, that an inspection of examinations furnishes material to judge of the standard of medical qualifications, should be radically revised.

There should be three examinations in the course :—

1. At the end of the pre-clinical period.
2. A year or 6 months, preferably a year, prior to the last year of study.
3. The final test at the end of the course, in medicine, surgery and obstetrics.

It is desirable that examiners should desist from asking about rare or complicated conditions, and should devote their attention to the commoner diseases met with in practice. Their task is to find out what the student knows, rather than what he does not know.

It is also desirable that examiners should devote some time to the preparation of the practical and clinical tests and should themselves conduct these tests, or examine fully and study the clinical cases before they are set to the students. An examiner should have no more facilities for the diagnosis of a case than are available for the candidate, and emphasis should be more on methods of approach and reasoning than on the giving of a diagnosis.

*Summary of recommendations on Medical Examinations.*

That there should be, in the whole medical course, two examinations held; one at the end of the pre-clinical period including the subjects of anatomy, physiology and pharmacology, and the other at the end of the clinical period when the following six subjects shall be offered :—

Preventive and social Medicine, Medical Jurisprudence, Medicine including Therapeutics and Medical Specialities, Surgery including Surgical Specialities, Obstetrics and Gynaecology including pediatrics, and Pathology.

That a student can pass in each subject separately provided, however, that he shall complete a pass in Medicine, Surgery, Obstetrics and Gynaecology within a maximum period of 18 months. The medical examinations should be held twice a year. (Note.—It should however, be open to the University

to hold an examination in the subjects of Pathology, Forensic Medicine and Preventive Medicine, six months to one year before the final examination in Medicine, Surgery and Obstetrics).

That no student shall be allowed to enter on his clinical course of studies until he has passed the pre-clinical examination.

That, so far as possible, external examiners should be associated with the conduct of the examinations, and that it should be the aim of all Universities to see that, in medical examinations, at least half the examiners are external.

There should be no attempt to impose a stereo-typed curriculum throughout the country. A wide margin of liberty should be allowed to individual medical schools and Universities to develop their own potentialities and ever to experiment. Reforms and improvements can more easily and quickly be brought about in this way. Where reforms have to await agreement among a large number of institutions, the results are invariably a compromise, and a sense of frustration is developed in those institutions, which desire to initiate reforms.

(f) *Internship as Home Surgeon or Physician.*—There should be, for all students, one year of internship after the final qualifying examination and the authority responsible should certify that that internship has been satisfactorily fulfilled. This period should not give the student the rights of a full practitioner, but during it he should work under the supervision of a Senior Officer.

That the conditions under which hospitals should be recognised for internship should be considered and definite rules laid down by the University. Such hospitals should be periodically inspected and reported upon.

The intern should not displace senior housemen, clinical assistants and resident assistants. The need for such senior housemen will be all the greater, for effective supervision and help.

A careful record should be maintained of clinical work carried on and such records should be certified by the Senior Officer under whom the student works.

During this period, in whichever ward he is posted, the intern should perform duties in the out-patient department and should work in the clinical pathological laboratories. During the whole of this period, he should be carefully supervised and guided.

That there should be latitude given to the authorities concerned to post the intern to any of the following assignments provided a three months' internship in a public health unit is always included.

1. Six months surgical or six months medical work.
2. Four months medical, four months surgical or four months obstetrical work.
3. Three months rotation including, medical, surgical, obstetrical work and public and rural health centres.

That the numbers of beds assigned to each intern should be between 10 and 20.

That the intern should be given free residence in the hospital and should receive a subsistence allowance of Rs. 60 to 75.

That, as far as possible, the intern should spend six months in a primary teaching centre either in the first or the second half of the period.

That, during the period of internship, a few lectures on medical and legal responsibilities should be given by a person selected by the University.

#### **Essentials in a hospital approved for interns.**

The hospitals approved for the training of interns during the last year of the graduate course should comply with some general basic principles. In enunciating these principles it is not intended to interfere with the administration, or the general policy, of individual hospitals which may be recognised for the above purpose. It is however believed that, in the interests of better medical education and of improved scientific and ethical care of the patients, there should be a wide agreement on the minimum requirements to be met regarding conditions of service, organisation of training and educational facilities available at such institutions. It is therefore considered that an acceptance of these general principles by the hospital authorities is necessary, if they intend to take up the training of interns.

**I. Hospitals eligible for approval.**—Only general hospitals should be eligible, which have at least 100 beds with a minimum daily average of 75 patients, and which provide a variety of medical, surgical, obstetrical and paediatric patients either in the hospital proper or through suitable affiliations with other institutions.

**II. Organisation.**—The organisation should consist of a Governing Body having authority and responsibility to execute the decision arrived at by such a body. In the case of Government, or Municipal, institutions this body should have statutory powers conferred on it, enabling it to give effect to its resolutions within the framework of the general policy and within the limits of the budget provisions sanctioned by the Government or the Municipality.

An Executive Officer, or a Superintendent, should be responsible for the actual carrying out of the resolutions adopted by the Governing Body. The Executive Officer should be assisted by adequate and competent personnel. Such an officer should be selected on an All-India basis and should not be appointed for a period of less than five years.

**III. Staff.**—The appointment of the staff constitutes the most essential feature in the organisation of an institution. The staff should be composed of regular physicians who are properly qualified as to training, licensure and ethical standing.

**1. Senior Staff.**—There must be an organised staff of physicians who hold the degree of doctor of medicine, or an equivalent post-graduate qualification, from acceptable medical colleges; who are of unquestioned professional and moral integrity; who are proficient in general practice, or in the special fields to which they devote themselves; who give personal attention to the patients under their charge and who will provide adequate facilities, instruction and that sympathetic cooperation without which interns and graduate students cannot obtain the practical training for which they are serving the hospital.

**2. Graduates in Medicine.**—The hospital must not only confine membership of its staff to reputable practitioners who have obtained post-graduate degrees but should also select a junior staff from suitable graduates in medicine. The conditions regarding ethics and character must apply to every person permitted to treat or prescribe for the sick in the hospital, or in any of its departments. Conditions regarding graduation do not apply to the treatment of patients by nurses, messengers, and technical assistants when acting under the orders of any physician on the attending staff.



3. *Staff Conferences.*—The hospital staff should conduct a regular monthly staff conference at which the work of the various hospital departments is considered and where interesting hospital cases and selected autopsy reports may be presented for general discussion. The interns should be expected to attend these meetings and should be encouraged to take an active part in the discussions.

IV. *Nurses.*—A competent nursing staff should be provided by employing a sufficient number of nurses who are graduates of schools of nursing recognised by the registering authority for nurses, or by maintaining a school for their training. All nursing should be supervised by qualified registered graduates.

V. *Records.*—The accumulated experience of most of the teaching hospitals in other countries has shown that no improvement in the treatment of patients and the training of medical students could be effected without the organisation and functioning of an efficient department of medical records. An adequate record system should therefore be maintained in all approved hospitals. No particular system or set of forms is recommended since requirements are not the same under varying circumstances. The average case record should conform to the following standards :—

1. The case records should be comprised of complete histories giving the patients complaint, physical examination at time of admission to the hospital, preliminary diagnosis, laboratory findings, description of operation, if any, progress notes, final diagnosis, condition on discharge and, in case of death, autopsy findings if secured.

2. Case Notes.—The histories should show, by signatures or initials, all persons writing them, or parts of them, as well as the staff members by whom the histories are verified. Likewise, all orders and progress notes should be initialled or signed.

3. A competent clerk should have charge of the records pertaining to patients. To be of educational value the records must be so handled as to be readily accessible when desired for special study or reference work. There should be an alphabetical index of patients, with cross files according to diagnosis, operations, etc. Lists should also be kept of patients according to departments, i.e., medical, surgical, obstetrical, paediatric, genitourinary, gynaecological, eye, ear, nose and throat, tuberculosis, etc., and of hospital days or daily average of patients, deaths and autopsies. Histories should be filed so as to be easily accessible. Complete monthly reports and annual summaries should be prepared covering the various hospital departments.

VI. *Laboratories.*—A clinical laboratory in the hospital should be equipped both for the ordinary routine tests, and also for the more technical bacteriologic, serologic, chemical, basal metabolic, and tissue examinations. A competent physician-pathologist (not only a trained technician) must be in charge of the laboratory, who shall supervise the work in general and personally examine all tissues from the operating rooms and furnish reports of gross or microscope findings as indicated. Records must be kept in the laboratory of all work carried out by the department, and copies should be filed with the patient's clinical record.

2. All tissues removed in the operating room should be examined, described and diagnosed by a competent pathologist, excepting tissues, such as tonsils and teeth, in which the pathologic changes are quite obvious.

A physician-pathologist should be employed on a full-time or part-time basis. When this is not practicable, arrangements should be made with a consulting pathologist for tissue diagnosis, post-mortem work and the interpretation of the more complicated tests and determinations in clinical and surgical pathology, as well as in general clinical laboratory work. The pathologist should preferably be one who has received specialised training after graduation for at least one year in Clinical Pathology at an institution recognised for this purpose.

3. In as much as the percentage of autopsies has come to be recognised as an index of the educational activities in a hospital, no institution should be approved for the training of interns which does not have a record of autopsies of at least 15 per cent. This condition may be difficult to comply with in all parts of India at present, but it should be the aim and endeavour of all hospitals to attain to it in the course of the next ten years. The autopsies should preferably be performed in the hospital by, or under the supervision of, the hospital pathologist who has special knowledge of this type of work and who can furnish reports that include a summary of the clinical records and a detailed description of gross and microscopic findings.

VII. *Library*.—1. A separate, suitable reading room in the building should be provided for the use of the medical staff and the interns. A librarian or library clerk should be appointed to look after the issue and care of books and journals.

2. An annual grant of at least Rs. 1,000 should be allocated for books and periodicals (i.e., excluding salaries of staff and cost of furniture, etc.) and of this amount at least Rs. 500 be spent on current medical periodicals (foreign and Indian Journals). The balance to be spent on reference books, monographs and annual reviews.

3. It is essential that all journals should be bound at the end of the year and kept for reference.

4. An initial expenditure of about Rs. 5,000 for purchasing reference books, etc. and perhaps including a microfilm reader would be a desirable addition.

The above suggestions relate to a hospital with 100 beds. For bigger hospitals with a larger staff and facilities for training a larger number of interns, a correspondingly larger expenditure on library facilities would be desirable.

VIII. *Department of Radiology*.—This department should be equipped for at least roentgenographic and roentgenoscopic procedures and must be directed by a physician-roentgenologist who is properly qualified for the work which the department purports to do. Records of the work carried out must be on file in the department, and copies should be filed with the clinical charts.

IX. *Records of Interns' Work*.—Each hospital should keep a weekly or monthly record of each intern's work. This information is most conveniently supplied to the superintendent of the record office by the interns themselves on special forms where space is provided for the following:—Period covered; service; number of patients admitted on service; number of histories and physical examinations; number of anesthetics given; number of operations assisted at; number performed; number of deliveries attended; number performed; autopsies attended; hours in laboratory; lectures attended; clinics attended, etc.

**X. Admission to the Approved List.**—Application for Approval. Hospitals that wish to be accredited for intern training should apply to the Council on Medical Education and Hospitals, or such organisation as may be properly constituted by the Universities. A list of approved hospitals should be circulated to the different Universities and the heads of medical colleges at stated intervals.

## PART II.

### THE REQUIREMENTS OF A MEDICAL COLLEGE.

(NOTE.—This subject is brought to the notice of the authorities concerned because of its importance in the light of new developments.)

(1) As a result of the survey of medical education, it is hoped that medical colleges will consider the need for reorganisation and that plans for extension and improvement of existing structures and facilities will be prepared.

(2) Active steps are being taken in several provinces to convert medical schools to medical colleges.

(3) It is expected that as a result of the recommendations of this Committee different provinces will open new medical colleges and plan them on modern lines.

It seems, therefore, desirable that there should be set down a general idea of the requirements of an ideal medical college.

*The ideal medical school* should be capable of providing the student with the whole of his medical education, from the time of his entering the school until he is qualified, after which a resident post should be found for him, either in his own school or elsewhere, before he goes into practice.

*Site.*—To allow adequate room for the erection of a medical school, it is suggested that a site of from 100 to 150 acres in extent should be available to accommodate :—

(a) The Medical School with its pre-clinical departments.

(b) A General Hospital.

(c) A series of special hospitals, institutes or units. The whole site should form a teaching hospital centre, and its component parts should be comprehensive enough to provide the nucleus of teaching in all subjects, as well as the direction of research and of post-graduate studies. Each of the institutes or units should be flexible enough in construction to allow for expansion if necessary.

(d) Quarters for a full-time staff.

An alternative suggestion is that the teaching centre shall provide units for the specialities to be utilised for undergraduate teaching, while special hospitals are located within a convenient distance and utilised for the instruction of post-graduates, and specialists who aspire to become consultants.

*Number of students.*—This must depend both on the accommodation and facilities available in the pre-clinical departments and on the number of beds and the clinical material available in the associated hospital.

The number of students that should be admitted into a medical school has been the subject of considerable discussion.

It has been suggested—

- (1) that 50 admissions a year is desirable,
- (2) that 60 to 70 should be an optimum, and
- (3) that normally 100 should be the maximum.

In the medical school proper there should be an adequate number of large and small lecture Halls ; laboratories, preparation rooms, etc. ; a library and reading rooms ; common rooms ; a department of research with special facilities.

Well planned and well equipped laboratories, however, cannot provide satisfactory service unless they are manned by an adequate number of suitably trained technical assistants. The selection of these should not be by the haphazard methods of the past. Their training should be systematised by instruction in technical schools or departments, and they should be adequately paid.

As distinct from individual departmental requirements, certain facilities and equipment of a general character are needed. Museums, including a radiological museum, should be readily accessible to all students and should contain sections specially arranged for teaching purposes. Means both for taking and for showing cinema films to students should also be provided.

Many departments such as Biology, Anatomy, Physiology, Pathology, Experimental Medicine and Surgery, Pharmacology, Bacteriology and Midwifery as well as the research unit require to maintain live stock. This need is best and most efficiently met by organising a central animal farm under the care of a Veterinary Surgeon, where Genealogical Histories would be kept. Each unit could indent on the farm but should have its own animal house under proper conditions where the department would carry out its investigations.

The actual accommodation of the departments should be on an ample scale so as to permit of any expansion to meet future requirements in the advance of medical education. Not infrequently work has had to be carried on under cramped conditions as old buildings have become out of date and inadequate for the expanding work of medical education and research.

*Hospital accommodation.*—The hospital in a teaching centre should be so designed and organised as to meet both the needs of the patients and the requirements of students and also to be suitable for the research work of the staff. Wherever post-war construction of teaching centres or reconstruction of such centres may be needed opportunity should be taken to see that all three aspects of work carried on in a teaching centre are fully provided for.

It is very desirable that a teaching hospital should be provided with proper residential accommodation for its full-time junior staff, for its students in their last year of study and for interns.

*Number of beds required in a teaching centre.*—The number of beds required should be based in general on the number of students admitted in a year. It may be stated that there should be 10 beds per student admitted, and that half this number should be for general medical and surgical cases in equal proportions, and the other half for the specialities, which should be provided for within the area of the teaching centre.

A rough plan would be to provide, in a 1,000 bed hospital, for—

					Beds.
Medical .. .. .	..	..	..	..	250
Surgical .. .. .	..	..	..	..	250
Obstetric .. .. .	..	..	..	..	100
Gynaecological ..	..	..	..	..	50
Ophthalmic .. ..	..	..	..	..	50
E. N. T. .. .. .	..	..	..	..	30
Dermatology .. ..	..	..	..	..	20
Radio-Therapeutics	..	..	..	..	"
Tuberculosis .. ..	..	..	..	..	20

						Beds
Dental	..	..	..	..	..	10
Orthopaedic with fractures	..	..	..	..	..	50
Pediatric	..	..	..	..	..	50
V. D.	..	..	..	..	..	25
Others	..	..	..	..	..	25
Research pool	..	..	..	..	..	50

It should be emphasised, however, that the number of teachers rather than the amount of clinical material or beds available should determine the number of students annually admitted.

There should be in each teaching hospital :—

1. Lecture rooms for clinical demonstrations.
2. Test-rooms.
3. Out-patient departments.

*Lecture rooms.*—There should be two main lecture rooms for the whole hospital, to seat at least 100 and equipped with black boards, facilities for micro-projection and for wheeling in patients, with an ante-room where they could be accommodated until required for demonstration.

One small clinical demonstration room for each unit, to accommodate about 30 students, is desirable.

*Test rooms.*—There should be one test room (ward laboratory) provided for each clinical unit. There should be at least one test room for the out-patient (general) and one test room for the skin and venereal departments.

*Clinical laboratory.*—There should be a large well equipped central laboratory for the whole hospital, where the more complicated tests, Bacteriological, Pathological and Biochemical, will be conducted.

*Out-patient Department.*—In many hospitals, perhaps the least well equipped and organised section is the out-patient department. Yet this department furnishes a wealth of clinical material for teaching purposes and, forming as it does a link between domiciliary practice and institutional practice, should be of the greatest value for teaching. The first essential in all out-patients departments is to make the out-patients comfortable during the long period of waiting. There should be adequate waiting, examination and undressing rooms, and arrangements made for some form of canteen service.

It is desirable to have separate small cubicles where the teacher may systematically examine the patient and demonstrate to the students. The mixing up of old and new cases is not desirable. Careful records should be kept, and an intelligent secretariat should be maintained for cataloguing and indexing the cards, and for issuing them to the patients. Every special department should have its own out-patient clinic.

The need for special laboratory facilities and for a diagnostic radiological outfit need not be emphasised.

The medical and surgical out-patient departments should be conducted by the medical or surgical units on their respective days for admission, and the students posted to the unit should attend the out-patient department on such days. Depending on the number of out-patient cases, it may be necessary for more than one unit (Medical or Surgical) to attend.

There should be a well organised casualty department in each hospital, situated in the out-patient department and every student should receive instruction in accident work.

*Adequate range and variety of cases and the linking up of hospitals for teaching purposes.*

Regionalisation of hospitals for undergraduate and post-graduate teaching will be of considerable use in as much as it will be possible to draw a great variety of cases from these hospitals for teaching purposes. The hospitals, if properly staffed, could be used for posting junior students as medical clerks or surgical dressers, for posting housemen and for refresher courses for students who had failed and were required to put in an additional three months work.

*Rehabilitation centres.*—Rehabilitation centres should be available at a convenient distance for use by teaching hospitals so that convalescents and chronic cases may be transferred to such centres and be under the care of a trained staff sent from the teaching hospital. Such centre, besides giving reasonable rest for the patient, would relieve the congestion in teaching hospitals and would enable the students to follow up cases by a weekly visit with a member of the senior staff.

*Staff of the Medical School and Hospital.*—The preclinical and clinical laboratory staff should be full-time, the heads of the respective departments being full-time professors with a sufficient number of senior and junior assistants and demonstrators. There should be 1 teacher for every 8 or 10 students, the number of demonstrators being restricted to two-fifths of the total staff. In all practical classes there should be at least 1 teacher to supervise 15 students and the practical classes should be small, the total number attending at a time being limited to 30 or a maximum of 40.

#### *Clinical Staff.*

*Types of teacher.*—There are three types of teachers who may be employed :—

1. *Heads of departments in charge of units.*—Those may be in charge of the three units of medicine, surgery and midwifery. These should be full-time.

2. *Part-time teachers.*—Part-time clinical teachers are valuable as they are in contact with the problems of general and consulting practice and can provide a variety of experience and teaching. They must, however, devote an adequate part of their time to teaching, and should receive remuneration for teaching duties and hospital services. Such salaries should carry with them definite obligations in this respect.

3. *Senior and junior teachers.*—These should be available in sufficient numbers. The senior teacher is best fitted for practical teaching, while the junior teacher is best fitted for the inculcation of routine methods of examining patients and for assisting the student with problems arising during his studies.

In making appointments to the staff of a teaching hospital teaching ability should carry due weight.

*Full-time staff (clinical).*—Full-time heads of the departments of Medicine, Surgery and Obstetrics, together with full-time assistants, are needed to organise teaching and research in the subjects.

The full-time professor should, however, have no control over the clinical work of part-time teachers, nor exercise any authority over other members of the staff who are not working under him directly, except in the matter of coordinating teaching in the department concerned. With good will on both sides and with a genuine interest in teaching an harmonious relationship ought to exist and the full-time head of the unit should be looked to

for help and advice in regulating teaching in the best interests of the school. For purposes of clinical lecture demonstrations, the clinical material of the hospital should be made available to all teachers (clinical and pre-clinical).

A full-time professor should be appointed without the right of practice. Such a person should be selected for his outstanding abilities and should have had a large experience of the practice of his profession, both domiciliary and institutional. His ability to teach and to enter into cordial relations with his colleagues should be taken into consideration. His salary should be such as to secure the right type and to free him from all financial embarrassment. A salary of Rs. 1,500—2,000 is not excessive.

*The junior teaching staff*, as well as one or two senior assistants, should hold whole-time salaried posts and should have no right to practice.

*Part-time appointments.*—Part-time clinical teachers are of value as they are in contact with problems of general and consulting practice and are best fitted to train future general practitioners. By their number they provide variety of experience and teaching. They must, however, devote an adequate part of their time to teaching. All hospital teachers in the clinical period should receive salaries. In the part-time posts, outside consulting work must not be allowed to impair the efficiency of hospital work and teaching, and some arrangements as to supervision and control should be made by the authorities of the hospital concerned. Regular attendance and regular hours of teaching should be observed by all members of the teaching staff; and other distractions, whether of administration or professional work, should not be permitted to prejudice this essential work.

*Status of teachers.*—It is of fundamental importance that medical teachers should have complete freedom in the control of the beds in their charge and in their methods of teaching and treatment. The teacher should have full clinical charge of the beds allotted to him subject only to the general administrative supervision of the Dean, or Superintendent, of the hospital.

Salaries may vary in the different grades but should be such as to attract in each grade the right type of person. Part-time clinical teachers may be appointed for a period of 5 years in the first instance and may be continued for a further period of 5 years subject to a satisfactory review of work at the end of each period.

The following scales are suggested :

	Rs.	p.	m.
Full-time Head .. .. .	1500	to	2000
Full-time Senior Assistant .. .. .	500	to	1000
Full-time Junior Assistant .. .. .	300	to	600
Part-time non-professional staff .. .. .	500		
Part-time Junior staff .. .. .	250	to	350
Registrar .. .. .	300	to	450
Senior residents .. .. .	200	to	300

For all full-time posts reasonable arrangement for study leave should be made. Facilities for study leave should also be available for part-time teachers when reappointed to their posts.

*Library.*—The position of the library should receive special consideration in a Medical College. It must be confessed that, in the past, library facilities both for the staff and for the students have been rather meagre. In medicine new books and new editions are constantly being published and no member of the staff can be expected to possess a complete library of his own. Medical

journals have also to be obtained in more than one language. A College should therefore make generous provision annually for its library. At the same time care should be taken to see that such facilities are made available to all members of the staff, and that a few senior members should not have a monopoly of the latest literature. Subject to the needs of the staff, the medical practitioners of the locality should have access to these books in the library premises, but not for taking away.

The need for a section of the library being reserved for students deserves emphasis. The heads of the departments should carefully select suitable books and see that they are made available to students. More than one copy may be needed in some cases. A proportionate allotment of funds should be spent on the students' library. This may be fixed at one-fourth of the total allotment. It is desirable that medical journals should also be made available to students, and that some selected journals should be kept in the students' reading room.

A well qualified librarian, preferably one who knows more than one modern European language, should be appointed on an adequate salary.

*Selection of Medical Students.*—This has been the subject of careful study in many countries. It is generally recognised now that, in the profession of medicine, the doctor is dealing with people rather than with abstract diseases. Although a scientific attitude is necessary in a doctor it is not absolutely essential, and character, culture and ability to deal with men often prove to be more practical attributes.

The selection of the best students is difficult and demands considerable experience. It may, however, be stated that while emphasis should undoubtedly be laid to a certain extent on academic attainments, a great deal has also to be placed on the previous college record, personality, physical fitness and character as judged by the share taken by the candidate in school and college activities such as sport, dramatic and debating societies and in public service. The general suitability of a candidate should be finally determined in a personal interview by a selection committee.

*Women students.*—In view of the large numbers of women doctors needed, every medical college should admit women students in reasonable numbers, and for some years special facilities should be made available in order to attract them. It is significant that, with the exception of the Government of Madras, which gives free medical education to women students, no other provincial Government has so far given any special facilities to women. Yet the need for women doctors is greater in Northern India than elsewhere.

A due proportion should be maintained of men and women doctors. The wastage is greater in the case of women doctors, both during training and subsequently. The ultimate proportion of men to women students should be approximately three to one.

*Summary of recommendations on the selection of students.*—That in the selection of students the academic record should be given its due weight but physical fitness and any special athletic record, inter-collegiate or inter-University, should be taken into account. When aptitude tests are available, they should be utilised in the selection of students, while a personal interview will serve a useful purpose.

That in judging academic records the University record should be taken into account. It is not desirable to hold a separate academic test to judge the standard.



*Recommendations as to women's education and the selection of women candidates.*—That in view of the large number of women doctors needed, more medical colleges should be open for women.

That facilities should be made available, by way of free studentships to encourage more poor and deserving women students to study medicine.

That the question of taking bonds from them to serve as Doctors for a certain period should be ultimately dropped.

*Research.*—General questions of medical research and the manner in which research should be organised, fostered, and encouraged are being dealt with by a separate sub-committee, but the place of research in a medical college needs consideration here.

The whole attitude of medical colleges towards research should be enlivened. It should be realised that a medical college does not entirely fulfil its functions if it contents itself only with training doctors and treating patients. The advancement of knowledge should be the third objective of every teaching unit.

In all teaching hospitals sufficient funds should be available for research, and the post-graduate education of the younger men should include ample opportunities for training in methods of original investigation. A block of beds should be set apart for a research unit and should be made available under suitable supervision, for teaching as well as for research.

There should be an advisory committee in the Hospital, on which should be representatives of the clinical, pre-clinical and scientific departments, which will advise as to the best provision to be made, for young medical graduates to be drilled in research methods.

*Deans of colleges and hospitals.*—The administrative responsibilities of colleges and teaching hospitals, the care of the students and the varied duties imposed on heads of institutions make it necessary to consider whether Deans of colleges and hospitals should not be appointed as whole-time officers with little or no teaching or clinical responsibilities. It is impossible for a person who is the head of a department to have the time or the energy to undertake these responsibilities without the sacrifice of some part of his more important duties.

The Dean should be appointed for a period not exceeding five years and should be selected from among the full-time professors. During this period he should have no clinical or teaching duties.

*Age of Teaching Staff.*—While there may be exceptional cases where members of the teaching staff can carry on their duties efficiently to an advanced age, it is desirable in general to limit the age to 55. Facilities for the continuance of research work should, however, be available to such officers, should they desire them after retirement.

*Grants to teaching centres.*—The question of assisting teaching hospitals by educational grants deserves careful consideration. Medical colleges are now managed by—

- (1) Provincial Governments.
- (2) Municipal Corporations.
- (3) Private bodies acting as Trusts or Corporations.
- (4) Mission Agencies.

So far there are no colleges managed by the Government of India direct, nor have any grants been specially given to medical colleges managed by any of the above bodies.

In the report of the Central Advisory Board of Education, the suggestion has been put forward that there should be a University Grants Committee erected, on the lines of the Grants Committee, to recommend treasury grants to various educational institutions. If such a committee is constituted, the medical college proper—i.e., the laboratories and departments of pre-clinical and clinical sciences, will share with other colleges of science in the allocation of grants. The amenities for students should also be considered.

For creating improvements in medical education, however, it is important that (1) teaching hospitals should receive grants with a view to ensure proper standards in teaching, treatment and research. The teaching hospital will have much greater commitments in salaries of teachers, and the number of men employed will be much greater than in a non-teaching institution. The hospital will require the services of full-time teachers who have made a mark in their profession, while part-time teachers should also be paid for their teaching and hospital duties. (2) The supply of proper accommodation for House-men, Junior and Resident staff and Deans, the equipment and special instruments needed, the laboratories, lecture rooms and cubicles for clinic both in the in-patient and out-patient departments, the better equipped operation theatres needed—all these require special grants. In the past, much of this accommodation and equipment has not been made available, with the result that teaching has too often suffered.

A special "Teaching Hospitals' Grants Committee" should be set up to recommend, obtain and award grants to these institutions, on the basis that the hospital does not fall below the standard of efficiency that should be aimed at by a properly equipped and conducted hospital. It may roughly be stated that a teaching hospital requires 25 to 35 per cent extra money for expenditure on items such as those mentioned above.

The grant may be based on two calculations—

(1) A basic allocation taking into consideration the number of students and the range of services available.

(2) A supplementary allocation related to special needs and the special features of individual institutions.

The distribution of the grants by this committee should be without prejudice to, or interference with, grants which may be given by the proposed University Grants Committee.

## APPENDIX 29.

*Scheme for the training of the basic doctor during his undergraduate course in preventive medicine and public health.*

The Sub-committee dealing with the curriculum for the training of the "basic" doctor dealt with the subject of undergraduate training in public health and preventive medicine at its meeting on Tuesday, 4th July, 1944. Among the papers circulated, an Interim Report of the Social and Preventive Medicine Committee of the Royal College of Physicians, London, (October 1943), a note by Dr. J. B. Grant, on "undergraduate training in preventive medicine and public health" and another note by him on "Hospital social service", received special consideration.

The following recommendations were made by the Sub-committee:—

1. The scheme of training for the basic doctor should incorporate the idea that the teaching of preventive and social medicine should permeate the whole course. The interim Report of the Royal College of Physicians (October 1943), on this subject must be consulted for a picture as to how this can be done by teaching in these matters running parallel with that of the three clinical subjects for a three-year course.

2. The department of preventive medicine and public health in a medical college must be provided with the same standard of academic facilities as are accepted as essential for the pre-clinical and clinical departments. This implies a full-time staff provided with facilities for the investigations of health problems in university controlled rural and urban community centres in which the student can be given opportunities of participation in supervised health work. The training in preventive medicine given to the student should be on the lines described under the heading "(B) Preventive Medicine for the General Practitioner" on pages 2 & 3 in Dr. Grant's note "Undergraduate Training in Preventive Medicine and Public Health". The method of teaching described is that which was developed in a modern college hospital and is quoted below for the sake of easy reference

"Patients residing in the Area who visited the hospital were utilised for follow-up from the preventive standpoint. Preventive teaching was based upon the following generalisations: (a) The primary aim of medical education is the preparation of general practitioners, (b) the goal of the medical profession should be medical service both preventive and curative, (c) a preventive habit is necessary to induce the general practitioner to adopt in his daily practice of medicine an attitude and spirit of scientific prevention, (d) habit can only be cultivated through the repetition of the same function under certain conditions. A preventive habit in clinical medicine can only be cultivated in the practice of clinical medicine and not elsewhere.

The procedure adopted was as follows: (a) individuals for preventive study were obtained through the hospital and outdoor, (b) investigation of the social-environmental factors of the cases and the microbiological aetiology of the disease was undertaken by officers of the Health Station of the Area.

(i) The first visit was to investigate home environmental factors, personal habits, family attitude and other social, health or related factors which might have a bearing on the illness;

(ii) The second visit was to check the extent to which the patient and family co-operated in following treatment and advice;

(iii) Subsequent visits were to collect any missing data and for follow-up of the case

(ii) Finally, at dismissal of a case, a summary was made of the findings including statements commenting on the value of the permeation procedure in the case.

Due both to the crowded clerkship period as well as that certain diseases more readily lend themselves to demonstration of prevention, preventive routines were practised only in the following eleven categories :—

1. Smallpox
2. Diphtheria
3. Scarlet Fever
4. Typhoid Fever
5. Syphilis
6. Gonorrhoea
7. Tuberculosis
8. Ante-natal cases
9. Postpartum cases
10. All children below age of five
11. Infantile diarrhoea.

A special officer from the Department of Public Health of the College was detailed specifically to the hospital to supervise the cases and the students' routines. Briefly the latter were as follows : All patients coming to the hospital from the area were designated by record forms of a special colour in order that students and hospital staff would be aware of the patients' residence. The Registrar notified the names of all such cases immediately to the Department's medical officer at the Health Station. Each case was taken up by a health visitor until the case was closed and where indicated by a medical officer. The reports of the results of the preventive measures undertaken were sent from the Health Station for inclusion in the patient's hospital record. In the meantime, if the patient was a hospitalized case, the medical clerk after completing his clinical routines, and if the case came under one of the 11 categories, would go to the patient's home to determine the social-environment or specific microbiological factors causing the disease and diagnose the preventive measures that might be indicated in each instance. This the student would add to his record of the case. Then on ward-rounds, the student would present 2 diagnoses : first, as to the clinical condition : and second, as to the aetiological factors together with, in each instance, the therapeutic recommendations indicated. Diagnoses and therapy would then be commented upon consecutively by the clinician and the public health officer. In case of death and autopsy, the case would be presented at the routine clinical-pathological-conference where diagnosis, etiology and prevention would be discussed jointly by the pathologist, clinician and the public health officer. Preventive results over a period reported were : Failed 8%, Indifferent 25%, Benefitted 67%. The most essential factor in " failure " or " indifferent ", was social economic in a community whose economic level was approximately that of urban India, the chief reason being that the College was not willing to provide the per capita funds for prevention which it provided for treatment. Thus while, on teaching grounds the hospital gave free treatment to 55% of patients and costing several lakhs per annum in order to demonstrate clinical diagnosis and therapy, the few required dollars per case were unobtainable to prevent recurrence of the etiological causes bringing the case to the hospital in the first instance."

3. Public health administration has three objects in view, namely, the maintenance of health, prevention of sickness and early diagnosis and cure of disease. It seeks to achieve these objects through organized community

effort in order to ensure their more effective fulfilment than if left to the responsibility of the individual. In the training of the medical student the responsibility for each of these different aspects of public health is shared by various teaching departments. For instance, the teaching of the student in the medical knowledge necessary for the maintenance of health is the responsibility chiefly of the Department of Physiology. That of prevention of disease is shared between Microbiology and Pathology; and the teaching of the application of the methods of early diagnosis and preventive treatment of disease is a responsibility shared between the teachers of Clinical Medicine, Surgery and Obstetrics. The task of the Public Health and Preventive Medicine Department of the college is that of demonstrating to the student the utilisation of the instruction given in these several departments in the life of the community, through organised effort, in order to achieve the three objectives outlined above. Such training can be given adequately only if the students are afforded opportunities to teach themselves through participation in the preventive health work carried out in a field centre under the direction of teachers, who are the health administrators. Separate urban and rural centers will be required for each medical college because the environmental and other health factors associated with the two types of areas vary widely.

4. An essential feature of such field training centres should be the provision for the required administrative control to the authorities of the medical college concerned. A method by which such control, on a basis of cooperation between local health authorities and the management of the college can be secured, may be illustrated by describing the Singur Health Centre which has been recently organised under the joint auspices of the Government of India and the Government of Bengal and which provides a field training centre to the All-India Institute of Hygiene and Public Health, Calcutta. The Government of Bengal and the Local authorities of the area included within the scheme together shoulder the financial burden for the health organisation that has been set up for the routine health administration of the centre. At the same time the Government of India is cooperating in the scheme by making available to the centre the technical advice and guidance which the Director, Professors and their Assistants of the Institute can offer. There is a Technical Adviser consisting of the Director of the Institute, the Director of Public Health, the Surgeon-General with the Government of Bengal and certain other officials. The day to day administration is in the hands of a Committee consisting of the Professors of Institute. The recruitment of personnel is to be done by the Technical Advisory Committee in order to ensure that the requisite standard of professional skill and training is secured.

In order to give the staff of the Institute the requisite legal standing for active participation in the health administration of the area, the necessary legal powers and the status of health officers have been conferred on them by the Government of Bengal.

5. From the point of view of the Provincial Government the main advantage that the centre offers is that it provides facilities for the development and demonstration of efficient methods of administration and for the training of health personnel in these methods. Successive batches of different types of health personnel will have to be trained if an adequate expansion of health services in the province is to be attempted within a reasonable length of time.

6. From the point of the Institute the advantages are that the centre provides facilities corresponding to a teaching hospital for the field training of the students as well as opportunities for the different sections of the Institute to investigate community health problems and experiments in methods of administration.

7. Another fundamental requirement for organising the teaching of social medicine on sound lines is the provision of an adequate social service attached to the teaching hospital. Such a service does not exist at present anywhere in India. The development of facilities for the training of hospital social workers is therefore urgently required.

8. As regards lectures, 25 hours should be devoted to an introductory course in social medicine, this training being given as early as possible in order to orient the outlook of the student. Perhaps the period which has been designated as a bridge between the pre-clinical and the clinical studies may prove suitable for the purpose. Fifty hours of lectures on public health are recommended for the third year and another week, comprising in all about 25 hours, between the 4th and 5th year, should be devoted to giving the students theoretical instruction regarding community health administration. Thus the theoretical training will total 100 hours.

9. As regards practical training, it is essential that the student should get one month's clerkship in the 4th year in the urban and rural centres together. After the qualifying examination of the total period of one year of internship, at least three months should be devoted to training in public health administration in the two types of centres. In view of the importance of the rural health problem in the country it is desirable that, of this period of internship, at least two months should be spent in the rural training centre. On the other hand, of the proposed clerkship of one month in the fourth year, the period may be equally distributed between the urban and the rural centres.

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## APPENDIX 30.

*Estimates of staff for a medical college put forward by the Goodenough Committee.*

*General Notes.*—(1) The nature of the appointments is indicated as follows:

- W.T. (M) .. Whole-time appointment on staff of the medical school.  
 W.T. (C) .. Whole time service within the teaching centre, although only a part-time member of the staff of the medical school.  
 P.T. (C) .. Part-time teacher of medical school and part-time member of medical staff of the teaching centre.

(2) The estimates are considered reasonable for a school that admits approximately 100 students a year to both the pre-clinical and clinical parts of the course.

(3) As stated in the report a common pattern of staffing for all medical schools would be undesirable. There are bound to be considerable local variations. *The estimates set out below are quoted merely to illustrate the scale of staffing which the Committee considers will have to be aimed at in future. Provision in the various departments not included among these examples should be of an order that will secure a proper balance.*

(4) It has been assumed that there will be a centralization of various services and accommodation, such as animal houses, mechanical and carpentry workshops, photographic and art departments. The technical staff given in the examples below is *exclusive* of technical staff on such centralized services.

(5) The provision for secretary-typists is intended for both medical school and hospital work of the departments.

## DIVISION OF PRE-CLINICAL STUDIES.

## DEPARTMENT OF ANATOMY.

*Assumption.*—The department will be responsible for teaching histology and the morphological aspects of biology, as proposed in chapter 7 of the Report.

- 1 Professor .. .. W.T. (M) .. Head of the department.  
 2 Readers or senior lecturers. W.T. (M) .. Normally the two readers will be specialist in those branches of anatomy in which the professor is not a specialist thus, if the professor is an embryologist, one of the readers might be a specialist in neurology and the other in the biological aspects of anatomy and possibly also in histology.  
 2 Lecturers .. .. W.T. (M).  
 Assistant .. .. W.T. (M).

(It has been assumed that the above will devote approximately half time to teaching and halftime to research).

- 6—8 Demonstrators .. W.T. (C) .. The number of demonstrators required will vary according to the amount of time which some may devote to the department. The estimate of 6—8 is based on the assumption that, on average, each demonstrator will spend 4—5 half-days a week in the department of anatomy, spending the rest of his time in the clinical departments.  
 .. .. be W.T. (M).

- 1 Teacher of radiological anatomy. Probably W.T. (C) but part-time (i.e. 2—3 half-days a week) in anatomy department.

Preferably this teacher should be on the diagnostic side of the radiology department of the parent teaching hospital.

*Technical assistants* [all W.T. (M)]

- 2 Grade A technical assistants .. One, say, for dissecting room, etc., and the other for histology and embryology.
- 2 Grade B technical assistants .. One, say, for biological work and the other for photo-micrography.
- 3 Grade C technical assistants.
- 2 Laboratory apprentices.
- Cleaners.

[See General Note (4) above].

*Secretarial assistance.*

- 1 Secretary-typist .. W.T. (M).

**PHYSIOLOGY (INCLUDING BIOCHEMISTRY, PHARMACOLOGY AND PSYCHOLOGY).**

*Assumptions.*—(1) The department will normally be organised in 3 sub-departments, viz. :—(i) human physiology; (ii) biochemistry (including biophysics); (iii) experimental physiology and pharmacology. (In some schools, experimental physiology and pharmacology may form separate sub-departments, while in other schools a sub-department of pharmacology might be associated with one of the clinical departments).

(2) At the head of each sub-department will normally be a professor, reader, or senior lecturer.

(3) One of the professorial heads of the sub-departments will act also as the head of the whole department.

- 3—4 Heads of sub-departments. W.T. (M) .. Each a professor or reader or senior lecturer.

- 4 Lecturers .. .. W.T. (M) .. To act as deputies to heads of sub-departments.

- 8—10 Assistant lecturers, assistants and demonstrators. A few (M), the rest W.T. (C). Distributed among sub-departments as required. As in the department of anatomy most of these teachers may be part-time in the department of physiology and part-time in the clinical departments.

*Technical assistants* [all W.T. (M)].

- 1 Grade A technical assistant .. } Distributed among the various sub-departments as required.
- 3—4 Grade B technical assistants .. }
- 4—5 Technical assistants in training .. }
- Cleaners.

[See General Note (4) above].

*Secretarial assistance.*

Minimum of 3 Secretary-typists [W.T. (M)].

**DIVISION OF PATHOLOGY.**

*Assumptions.*—(1) The division of pathology will normally be divided into 4 departments, viz. :—(i) morbid anatomy; (ii) bacteriology (iii) chemical pathology; (iv) clinical pathology.

(2) At the head of each department will be a professor, reader or senior lecturer.



(3) The director of the division of pathology will be the departmental head most suited to administrative work.

(4) The various departments will be responsible for the pathological work of the parent teaching hospital and perhaps also of certain associated teaching hospitals.

4 Departmental heads ..	W.T. (M)	..	Professors, readers or senior lecturers.
4 Lecturers ..	W.T. (M)	..	One for each department. They will be persons of 4 or more years' experience in their subject.
4 Resident assistants ..	W.T. (M)	..	One for each department. They will be persons who propose to make a career in pathology.
4 Demonstrators ..	W.T. (M)	}	One whole-time and one part-time for each department. Some may be obtaining experience in pathological procedures before embarking on a career in clinical medicine or surgery.
4 Demonstrators ..	W.T. (C)		

In some places additional assistants may be required in one or more of the departments. Additional staff, such as post-graduate trainees in pathology (*i.e.* men who intend to become pathologists but are not yet fitted to be in charge of either routine work or teaching) and special research workers, may be distributed among the departments of the division as may be convenient. Pathologists working with special departments have not been included.

*Technical assistants.* [W.T. (M)].

	Morbid Anatomy.	Bacteriology.	Chemical Pathology.	Clinical Pathology.
Grade A technical assistant.	1	1	1	1
Grade B technical assistant.	4 (1 for post-mortems. 1 for museum, 1 for teaching, 1 for research.)	1 for media 1 for teaching. 1 for research	1	5 (3 for hospital work, 1 for teaching; 1 for research).
Grade C technical assistant.	2	2	2	
Boy in training ..	1	1	1	
Cleaners ..	1	1	1	

[See General Note (4) above].

*Secretarial assistance.* [W.T. (M)].

Secretary-typist ..	2 (1 for post-mortems and museum).	1	1	1
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## DIVISION OF MEDICINE.

### DEPARTMENT OF GENERAL MEDICINE (INCLUDING NEUROLOGY).

*Assumptions.*—(1) For the purposes of teaching and research the department will have a whole-time professor of medicine as its academic head, and for teaching and research purposes will be organized on the lines described in chapter 9, paragraph 20.

(2) The department will have 250 beds.

(3) The professor of Medicine will be the academic head of the division of medicine.

- |  |   |   |
|--|---|---|
| 1 Professor of medicine                | W.T. (M) ..   | Academic director of department and physician in teaching centre.   |
| 2 Readers or senior lecturer.          | W.T. (M) ..   | One will be deputy academic director. Each will be a physician in teaching centre.  |
| 3 Physicians and assistant physicians. | Most P.T. (C) :<br>but some of the junior assistant physicians may be W.T. (C). | It has been assumed that these clinical teachers will normally devote half-time or more to the work of the teaching centre (including teaching and research). |
| 10 Assistants ..                       | .. W.T. (C) ..  | Includes grades now some-times called Registrar. Four of the assistants should be resident.   |
| 10 Pre-registration house-physicians.  | W.T. (C).   |   |

In some medical schools there may be in addition to the professor of medicine other whole or part-time professors in this department, e.g., a professor in neurology.

*Technical assistants.*

- |   |             |   |
|---|-------------|---|
| 5 Technical assistants of various grades. | W.T. (M) .. | To serve all departments of the division of medicine. |
|---|-------------|---|

*Secretarial assistance.*

- |                        |             |   |
|------------------------|-------------|---|
| 6 Secretary-typists .. | W.T. (M) .. | To serve all departments of the division of medicine. |
|------------------------|-------------|---|

[With regard to other departments in the division of medicine see General Note (3) above.]

## DIVISION OF SURGERY.

### DEPARTMENT OF GENERAL SURGERY.

*Assumptions.*— (1) For purposes of teaching and research the department will be organized on the same lines as the department of general medicine and will have 250 beds.

(2) Surgical specialities are included except ear, nose and throat and ophthalmic departments.

- |                                       |                                   |  |
|---------------------------------------|-----------------------------------|--|
| 1 Professor of surgery ..             | W.T. (M) ..                       | Academic director of the department and surgeon in the teaching centre.                  |
| 3 Readers or senior lecturers.        | W.T. (M) ..                       | Deputy academic directors of department (one may be a reader in experimental surgery).   |
| 8 Surgeons ..                         | .. P.T. (C) ..                    | Devoting half-time to the work of the teaching centre (including teaching and research). |
| 10 Assistants ..                      | .. Some W.T.(C), others P.T. (C). | Some will be resident.   |
| 8—10 Pre-registration house-surgeons. | W.T. (C).                         |  |

In some schools there may be, in addition to the professor of surgery, other whole time or part-time professors in this department.

*Technical assistants.* [W.T. (M)].

- |   |    |   |
|---|----|---|
| 5 Technical assistants of various grades. | .. | To serve all departments of the division. |
|---|----|---|

*Secretarial assistance.*

- |                        |             |   |
|------------------------|-------------|---|
| 6 Secretary-typists .. | W.T. (M) .. | To serve all departments of the division. |
|------------------------|-------------|---|

[With regard to other departments of the division of surgery see General Note (3) above.]

### DIVISION OF OBSTETRICS & GYNAECOLOGY.

*Assumptions.*—(1) For the purposes of teaching and research the division will have a whole-time professor of obstetrics and gynaecology as its academic head.

(2) The division will have 100 obstetrical and 50 gynaecological beds.

(3) The staff will be responsible for some domiciliary midwifery work and for the teaching of both obstetrics and gynaecology.

- |                                     |              |  |
|-------------------------------------|--------------|--|
| 1 Professor .. ..                   | W.T. (M) ..  | Academic director.   |
| 1 Reader or senior lecturer.        | W.T. (M) ..  | Deputy academic director.  |
| 2 Obstetricians and gynaecologists. | P.T. (C) ..  | Will be senior clinical teachers.  |
| 6 Assistants .. ..                  | W.T. (C) ..  | This number is desirable if the division is to train future specialists. |
| 7 House-surgeons ..                 | W.T. (C). .. |  |

[One of the senior staff and one of the assistant physicians on the staff of the department of child health will be associated with the division of obstetrics and gynaecology in respect of the care and management of new-born infants.]

*Technical assistants.* [all W.T. (M)].

3 Technical assistants of various grades.

*Secretarial assistance.*

3 Secretary-typists .. W.T. (M).



## APPENDIX 31.

*Draft courses for the Bachelor of Dental Surgery Degree.*

The degree of Bachelor of Dental Surgery shall be awarded to a candidate who having passed the Intermediate examination in Science of an approved University with Physics, Chemistry and Natural Science as the subjects of study has put in attendance at approved courses of study for a period of not less than four years. There shall be four examinations, 1st, 2nd, 3rd and Final professional examinations for the B. D. S. The examination shall be written, Oral and Practical. The subjects covered in the different years of study shall be as follows :—

*Four years' B. D. S. Course.*

(Open to students who have passed the F.Sc. Examination medical Group, or equivalent examination).

**FIRST YEAR.****(a) Lectures :—**

1. Human Anatomy.
2. Human Physiology with Histology.

**(b) Practical :—**

1. Dissections and Anatomical Demonstrations in Anatomy.
2. Practical Physiology with Histology.

First Professional B. D. S. Examination in Anatomy and Physiology with Histology.

**SECOND YEAR.****(a) Lectures :—**

1. General and Dental Materia Medica.
2. General Pathology and Bacteriology.
3. Medicine.
4. Surgery.
5. Human and Comparative Dental Anatomy, Physiology and Dental Histology.
6. Junior Dental Prosthetics.

**(b) Practical :—**

1. Elementary Pharmacy and Demonstrations in General Materia Medica.
2. Practical Pathology and Bacteriology.
3. General Hospital Practice with instructions in Clinical Medicine and Surgery in the Hospital.
4. Practical Dental Histology.
5. Dental Prosthetics Laboratory Instructions.

Second Professional B. D. S. Examination in General Pathology and Bacteriology, Human and Comparative Dental Anatomy, Physiology and Dental Histology and General and Dental Materia Medica.

**THIRD YEAR.****(a) Lectures :—**

1. Medicine.
2. Surgery.
3. Dental Surgery and Pathology with Dental Bacteriology.
4. Senior Dental Prosthetics. Crown and Bridge Prosthesis.
5. Dental Metallurgy.
6. Operative Dentistry

**(b) Practical :—**

1. General Hospital Practice with instructions in Clinical Medicine and Surgery in the Hospital.

2. Practical Dental Pathology and Bacteriology.

3. Dental Prosthetic Laboratory Instructions.

4. Junior Tutorial Practical Class in Operative Technique.

5. Dental Hospital Practice.

Third Professional B.D.S. Examination in Medicine, Surgery, Dental Surgery and Pathology with Dental Bacteriology.

***Fourth Year.*****(a) Lectures :—**

1. Oral Surgery and Anaesthetics.

2. Orthodontia.

3. Dental Radiology.

**(b) Practicals :—**

1. Clinical Demonstrations in Orthodontia, Dental Radiology and Dental Surgical cases.

2. Dental Prosthetic Laboratory Institutions.

3. Senior tutorial Practical Class in Operative Technique.

4. Dental Hospital Practice.

Final Professional B.D.S. Examination :—

**Part A :—**

1. Dental Prosthetics including Crown and Bridge Prosthesis.

2. Dental Metallurgy.

**Part B :—**

1. Operative Dentistry and Dental Radiology.

2. Oral Surgery and Orthodontia.

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## APPENDIX 32.

*Syllabus for the ' Diploma ' course in Pharmacy.*

*Admission requirements, etc.*—Matriculates or candidates with equivalent qualification will be eligible for admission to this course. Students with additional training in mathematics and science subjects will be given special preference at the time of admission. The candidates must be not less than 15 years of age at the date of admission. The Matriculation certificate or a certificate from the head of the institution in which the candidate last studied will alone be accepted as evidence of age.

Persons who have passed the Compoundership Examination under the State Medical faculty of Bengal may join the Diploma in Pharmacy Course, if desired. Such students will be required to undergo training for one year only. The course of studies and special exercises which they will have to take will be decided by the Pharmaceutical Council that will be created, subject to the final sanction of the local Government.

*Terms, lectures, etc.*—The course of study will be for two years. A year shall be split into two terms of four and half months each, inclusive of holidays, for theoretical lectures and practical work in the institution. The last three months of the year shall be set apart for practical work either in recognised drug stores, hospitals, or manufacturing firms (apprenticeship period). If this cannot be arranged, this period may be spent in the college laboratory doing special practical exercises under the guidance of teachers. The first term may be fixed from 1st July to 14th November and the second term from 15th November to 31st March. The apprenticeship period will therefore fall from the 1st April to 30th June of each year.

Every lecture shall cover a period of not less than 45 minutes inclusive of time allowed by the college rules for the assembling of the students. A period of practical work or class exercise or class examination of not less than 45 minutes shall be considered to be equivalent to a lecture.

No student shall be considered to have prosecuted a regular course of study in any subject for an examination unless he has attended at least 75 per cent. of the lectures delivered in that subject.

The candidates must maintain laboratory note-books for all practical classes which shall be examined and marked by the examiners. The note books must be signed at frequent intervals by the Professor under whom the candidates work.

*Class examination, etc.*—The candidates shall be required to pass an examination in each term which will generally be held in the last week of each term and shall consist of written, oral and practical examinations in which due consideration shall be given to the credits obtained by the examinees during their whole sessional work. A student failing to pass in two subjects in a term will not be promoted to the next higher class. For those who fail in one subject only, a provisional promotion to the next higher class may be permitted, provided he submits to a fresh examination in this subject during the period of the second term. Fresh attendance at theoretical lectures and practical demonstrations need not be insisted upon unless the candidates have also failed in the practical part of the test examination or have proved themselves particularly backward in sessional work. A candidate who has secured the minimum pass marks in sessional work in

any subject at any examination, if re-appearing at the same examination in any subsequent term, may have his previous pass marks in the sessional work in that subject re-credited to him.

*Final examination.*—The final examination shall be conducted under the auspices of a Board authorised to grant the diploma. The examination shall be held twice a year and shall consist of written, oral and practical examination. Sessional work will also be taken into consideration. Diploma will be granted after passing the final examination and on satisfactory completion of at least two apprenticeship terms in a recognised institution to be decided upon by the "Pharmaceutical Council".

A candidate who fails to pass the final examination may be admitted to one or more subsequent examination provided that he has attended a fresh course of instruction to the satisfaction of the Principal of the college. After four failures, a candidate shall not be admitted to any further examination.

*Curriculum for the Diploma in Pharmacy Course, showing the distribution of subjects to be taught in each term, and the number of lectures and practical classes.*

	Theoretical classes per week (hours).	Practical classes per week (hours).
<b>First year—First term :</b>		
1. Biology—(i) Botany .. .. .	2	4
(ii) Zoology .. .. .	2	4
2. Physics .. .. .	2	2
3. Inorganic Chemistry .. .. .	2	2
4. Anatomy and Physiology .. .. .	4	4
5. Pharmaceutical Arithmetic .. .. .	1	..
<b>Total</b> .. .. .	<b>13</b>	<b>16</b>
<b>समयमेव जयते</b>		
<b>First Year—Second term :</b>		
1. Physics .. .. .	2	2
2. Inorganic Chemistry .. .. .	2	..
3. Theory and Practice of Pharmacy .. .. .	4	4
4. Pharmaceutical Latin .. .. .	1	..
5. Hygiene, First Aid and Dressing :		
(i) Hygiene & Sanitation .. .. .	2	..
(ii) First Aid .. .. .	2	2
(iii) Dressing .. .. .	1	2
<b>Total</b> .. .. .	<b>14</b>	<b>12</b>
<b>Second Year—First Term :</b>		
1. Organic Chemistry .. .. .	4	4
2. Pharmacognosy .. .. .	3	4
3. Theory and Practice of Pharmacy .. .. .	2	2
4. Dispensing Pharmacy .. .. .	2	4
5. Forensic Pharmacy .. .. .	2	..
6. Pharmaceutical Economics .. .. .	3	..
7. Quantitative Analysis .. .. .	..	8
<b>Total</b> .. .. .	<b>16</b>	<b>22</b>

	Theoretical classes per week (hours).	Practical classes per week (hours).
Second year—Second Term.		
1. Pharmaceutical Chemistry .. ..	4	6
2. Theory and Practice of Pharmacy .. ..	4	8
3. Dispensing Pharmacy .. ..	2	4
4. Pharmacognosy .. ..	3	4
5. Materia Medica, Pharmacology and Toxicology .. ..	4	..
Total ..	17	22

*The two-year curriculum for the Diploma in Pharmacy Course Showing the number of Lectures and Practical classes required.*

	Lecture hours.	Lab. hours.	Total hours.
Biology (i) Botany .. ..	25	30	55
(ii) Zoology .. ..	25	30	55
Anatomy and Physiology .. ..	60	30	90
Physics .. ..	60	60	120
Inorganic Chemistry .. ..	40	60	100
Qualitative and Quantitative Analysis, including clinical examination of urine .. ..	..	120	120
Organic Chemistry .. ..	60	60	120
Theory and Practice of Pharmacy (including Pharmaceutical Technique and Operations, Examination of Pharmacopoeial substances, etc.) .. ..	150	150	300
Dispensing Pharmacy .. ..	60	120	180
Pharmacognosy .. ..	50	90	140
Pharmaceutical Chemistry .. ..	80	60	140
Pharmaceutical Latin .. ..	20	..	20
Pharmaceutical Arithmetic .. ..	20	..	20
Pharmaceutical Economics .. ..	20	..	20
Forensic Pharmacy .. ..	30	..	30
Hygiene, First-Aid and Dressing—			
(i) Hygiene & Sanitation .. ..	30	..	30
(ii) First-Aid .. ..	30	30	60
(iii) Dressing .. ..	15	30	45
Materia Medica, Pharmacology and Toxicology .. ..	60	..	60
Total ..	835	870	1,705

*Note:—*The “Syllabus” is intended to indicate the subject matter that may be profitably taught, the minimum amount of time that should be spent in presenting such material to the students and the examinations that should be conducted to test the professional and applied knowledge of the candidates. It is not designed to interfere with any flexibility in course of study or freedom in methods of instruction as may be thought fit by the teaching staff.



## APPENDIX 33.

*Syllabus and entrance requirements for the proposed Diploma in Public Health Engineering.*

The course will consist of academic instruction and demonstrations for 8 months or 1,150 working hours, followed by an examination, and 6 months of assigned practical training at selected centres. In the case of candidates not already in services, the practical training will be extended to 1 year. The candidate will be awarded a degree or diploma such as M. Sc. (Public Health Engineering) after satisfactory completion of practical training.

Admissions should be restricted to Engineers between the ages of 25 and 40, already engaged in the Provinces and States of India, industrial organisations, municipalities and corporations, on works related to public health,—such as water supplies, sewage works, refuse disposal, housing, malaria, control etc. Applicants should be carefully selected, should possess a degree in engineering as proof of a theoretical background and should be recommended by their employers for the special course. They should be given leave and other facilities. They should be guaranteed security of their position.

## SYLLABUS.

The course will include the study of eight compulsory subjects and one of three optional subjects.

## COMPULSORY SUBJECTS.

1. *Sanitary bacteriology*.—Bacterial environment, metabolism, carbon and nitrogen cycles. The role of bacteria in disease. Collection of samples of water for bacteriological examination. Bacteriology of water, sewage, soil, air, milk, etc. Sterilisation.

Approximately 14 lectures and 30 hours practical.

2. *Sanitary biology*.—Algae, fresh water biology, typical organisms of sewage, sludges, activated sludge, trickling filters, etc. River pollution and beach pollution and their effects. Life of animals and insects concerned in the transmission of important diseases. Disinfection, fumigation, disinfection. Elementary physiology and nutrition.

Approximately 48 lectures and 30 hours practical.

3. *Epidemiology and Public Health Administration*.—Origin and spread of the more common diseases such as malaria, smallpox, cholera, typhoid, plague, typhus, influenza, tuberculosis, etc. Relation between environment and health. Personal hygiene and prophylaxis. Organisation and administration of public health in India and elsewhere. Port health and quarantine.

Approximately 45 lectures and 30 hours practical.

4. *Statistics*.—General and vital statistics. Application of statistics to engineering problems of rainfall, run off, floods, population growth, sewage and water treatment.

Approximately 25 lectures and 40 hours practical.

5. *Water supply and sewerage*.

(a) *Water Supply*.—Design of projects of various types. Methods of preliminary investigation of new projects. Estimates of requirements of water, and the development and conservation of various types of sources of water supply. Rainfall, runoff, and yield of catchments. Statistical analysis of data of estimation of minimum yield, maximum floods, etc.

Ground water. Relation between geology and water supplies. Yield and development of wells and tube wells. Design and construction of river intakes, storage works, clear water and service reservoirs, balancing tanks, stand pipes, pumping stations, etc. Design of pumping plant, air lift systems, etc. Distribution systems, pressures and capacity. Specification and construction of water works ; pipe lines and ancillaries. Pumping. Hot water supply. Economics and maintenance of water works.

(b) *Drainage and sewerage*.—Design and investigation of sewerage and drainage projects. Estimation of sewage, infiltration of ground water and storm water from data on population, soil, intensity and duration of storms, etc. Hydraulics and design of separate and combined sewers and drains, syphons, separators, manholes, silt pits, etc. Ventilation, cleansing and maintenance of drains and sewers. Design of sewage pumping stations and equipment.

Approximately 100 lectures and 200 hours practical.

6. *Theory of water purification and sewage treatment*.—Wholesome water. Standards for public and industrial use. Quality of water and sewage. Chemical and bacteriological analysis and their significance. Biochemical oxygen demand and its determination. Principles of sedimentation, coagulation, control of algae, filtration, aeration, taste and odour control, disinfection of water and sewage effluents. Water softening. Corrosion control and incrustation control. Removal of iron, manganese, etc. Sedimentation of sewage. Anaerobic digestion of sludge. Sludge gas collection and utilisation. Activated sludge process. Trickling filters. Stability tests for sewage effluents and determination of their strength. River pollution problems. Analysis and specifications of chemicals used in water purification and sewage treatment. Manurial value of sewage. Dilution and irrigation. Elementary analysis of gases.

Approximately 40 lectures and 60 hours practical.

7. *Design of water purification and sewage treatment plants*.—(a) Design and construction of structures for screening, aeration, chemical treatment, (coagulation), rapid and slow sand filtration, disinfection, softening, deferri-sation etc. Water laboratories.

(b) Design and construction of structures for screening, grit removal, sedimentation and skimming of septic, Imhoff, sludge digestion and humus tanks ; trickling filters, contact beds, activated sludge plants, sludge drying beds, vacuum filters etc. Disposal of effluents on land and in waters. Estimating river pollution and safe loads for self purification. Sewage laboratories.

Approximately 100 lectures and 150 hours practical.

8. *General sanitation*.—(a) Street cleansing, refuse collection and disposal by various methods, including incineration and composting.

(b) Ventilation, air conditioning, heating, cooling, noise and dust control, smoke abatement. Methods of air and gas analysis, dust counting etc.

(c) Principles of village and town planning, zoning, healthful housing, and slum clearance.

(d) Type plans, construction and sanitation of hospitals, schools, slaughter houses, dairies, food and drink establishments, markets, eating establishment, swimming pools, disinfector stations, etc. Rat proof and fly proof and mosquito proof construction. Sanitary survey and reporting.

(d) Rural sanitation problems. Latrines and trenching grounds.

Approximately 40 lectures and 70 hours practical.

*Optional Courses* (of which one is to be selected).

1. *Malaria engineering*.—Life history and habits of vectors. Malaria surveys. Recurrent, naturalistic, and permanent methods of controlling larvae and adult mosquitoes. Design of antimalarial drains in various circumstances. Canalisation. Flushing. River training. Clearing. Sub-soil drainage. Filling. Adult spray killing methods. Construction of sprays. Preparation of larvicides and insecticides. Screening of houses. Relation between engineering construction, irrigation and malaria. Malaria control for engineering projects, etc.

Approximately 25 lectures and 75 hours practical.

2. *Industrial Hygiene*.—Elementary physiological hygiene. More detailed class and laboratory instruction on ventilation, air conditioning, dust, smoke and fume control, occupational risks, abnormal atmospheres, safety measures, comfort, etc.

Approximately 25 lectures and 75 hours practical.

3. *Disposal of industrial wastes*.—Nature and treatment of wastes produced at various stages in the leading industries in India, such as textiles, paper, brewing, tanning, dyeing, metals, etc., etc.

Approximately 40 lectures and 60 hours practical.

*Practical training for the degree of Master of Science in Sanitary Engineering*,

The academic instruction for 8 months proposed for this course will be supplemented by practical training as in the case of other branches of engineering in order to give the student a real insight into some of the actual problems awaiting him, and the prevailing engineering practices, whether they are modern or out-of-date.

The practical training will consist generally of the following :—

(1) Engineering and Sanitary investigation of projects—for water supplies, improvements etc. for drainage, sewage purification etc. for 25 working days.

(2) Design, drawing and estimating for such projects for 25 working days.

(3) Actual construction of sanitary works—water supplies, sewage works, refuse disposal plants, markets, hospitals etc.—for 25 working days.

(4) Operation and maintenance of water purification plants, sewage treatment plants, refuse treatment plants, laboratory control of plant operation etc.—for 25 working days.

Additional training may be given in the optional subjects, or the training outlined above may be intensified or prolonged at the option of the candidate or of the Director of the Institute.

The training may be arranged with the public health engineering departments of the Governments of Madras, Bombay, Delhi, Punjab, United Provinces, Bengal and Mysore, or with Corporations of Madras, Bombay, Karachi and Calcutta or at Tatanagar or Hyderabad (Deccan). In each case the Director of the Institute will negotiate and arrange details to ensure the right type of training and supervision. Students will be consulted and assigned to their own provinces for training if possible. In special circumstances, a student who is employed already on important public health engineering works may be allowed to count his service towards such practical training.

During the period of practical training students must work under the administrative control of the officers to whom they are assigned, and observe all the disciplinary rules in force. They must submit a report on their work and a record of their attendance through the respective officers under whom they may be undergoing training. The officers will also report confidentially to the Director, about the work of the trainees. Besides, the Professor of Sanitary Engineering may, if he wishes, inspect the work of the students during their training.

When the practical training prescribed or approved for each student has been satisfactorily completed, the Director will recommend the award of the degree to the student.



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## APPENDIX 34.

*Course in Public Health engineering for engineering students qualifying for a degree in Engineering.*

I. *Introduction.*—Engineering operations must be carried out without endangering public health. The best way to ensure this will be by providing elementary instruction on the essential principles of health, the causation of disease, the relation between engineering construction and public health, and the ways in which the engineer can cooperate with the health organisation in the ordinary course of his duties.

The present graduate course in engineering is already overburdened and involve the applications of basic scientific principles in various fields. Sanitary engineering is taught only to civil engineers, mainly as the application of the principles of hydraulics in the field of water supply, drainage and sewerage. It occupies a minor place in the curriculum leading to a Civil degree. It cannot be called public health engineering, though it is the nearest approach to it.

II. *Scope and weightage to be allotted to the course.*—It is obviously impossible to teach public health engineering in detail, but every engineer and subordinate may be given instruction in elementary public health principles through lectures for about 30 hours in the class room and demonstrations for 50 hours, without seriously overburdening the course. There must be a separate paper on public health engineering for all engineering students, carrying 5 to 8% of the total marks in the final examination.

III. *Syllabus.*—The syllabus may be as follows :—

	Lecture hrs.	Demonstrations hrs.
<b>A. Introductory :</b>		
Scope of public health and sanitation, Evolution of modern public health, ancient and modern theories .. ..	1	..
Elementary physiology and nutrition .. ..	2	4
<b>B.—Communicable Diseases :</b>		
Bacteria,—their biology, environment, metabolism, functions in nature's economy-carbon and nitrogen cycles, etc. ..	2	8
Infection, contagion, transmission, incubation, contacts, carriers, immunity, epidemics and endemics .. ..	1	..
Cholera, typhoid, dysentery .. ..	1	..
Smallpox, vaccination, vaccines, viruses, colds, influenza ..	1	..
Plague .. ..	1	..
Malaria, yellow fever, dengue .. ..	1	..
Hook worm .. ..	1	2
Tuberculosis .. ..	1	2
<b>C. Entomology :</b>		
Mosquitoes .. ..	1	2
Flies .. ..	1	2
Rats and fleas, lice .. ..	1	2
<b>D. Application :</b>		
Personal hygiene .. ..	1	..
Water, water purification, sanitary aspects .. ..	2	4
Sewage, sewage purification, latrines .. ..	2	4
Air, ventilation, dust, smoke, fumes and lighting .. ..	2	4
Refuse collection and disposal, fly control .. ..	1	3
Disinfection and disinfection .. ..	1	2
Food and milk, dairies, refrigeration, boiling, preservation, handling and transport, restaurants .. ..	2	3
Malaria control .. ..	2	4
Malaria and engineering construction .. ..	1	2
Hygiene of housing .. ..	1	2
	<hr/> 30	<hr/> 50

IV. *Position of this subject in the General Course.*—The best time to teach this course will be at the end of the 3rd year, or in the first term of the final year. The course requires only 16 additional working days and may actually be spread over a period of two months, allotting 2 hours every day for public health engineering during those 2 months. There are a number of holidays in the ordinary College term, and it will be possible to cut down these holidays by 16, or to give special evening classes. Thereby, no part of the regular engineering instruction need be omitted. But the course must form an integral part of the curriculum, and candidates must obtain a pass in this subject to qualify for the degree or diploma.

The instruction may be given by visiting lecturers if there is no competent person in the faculty of the College to teach any subject. Care must be taken to emphasise the engineering implications, not the clinical aspects.



## APPENDIX 35.

**A short course of training in public health engineering for engineering supervisors in small municipalities.**

**I. Length of Course.**—The course may consist of academic instruction for 3 months, followed by assigned practical training for 3 months so as to meet their actual needs, on which the students will report in detail.

**II. The Curriculum may be as follows :**

		Hours.	
		Lectures.	Lab.
<b>A. Introductory.</b>			
	Scope of public health and sanitation, ancient and modern theories .. .. .	1	..
	Elementary physiology and nutrition .. .. .	3	6
<b>B. (a)</b>	Elementary bacteriology, environment, biology, metabolism and functions of bacteria. Bacteria of water, sewage, milk, air, soil, use of microscope .. .. .	6	15
<b>(b)</b>	Biology of water purification and sewage disposal, river pollution, fish life, etc. .. .. .	3	6
<b>(c)</b>	Entomology—Mosquitoes, flies, rats, fleas, ticks, lice, sandflies, ankylostoma .. .. .	7	14
<b>(d)</b>	Chemistry of water purification and sewage treatment, including disinfection .. .. .	6	12
<b>C. Communicable diseases.</b>			
	Malaria, yellow fever, dangué .. .. .	1	} 4
	Plague .. .. .	1	
	Cholera, typhoid, dysentery .. .. .	1	
	Hockworm .. .. .	1	
	Tuberculosis .. .. .	1	
	Pneumonia, influenza .. .. .	1	
	Smallpox, chickenpox, etc. .. .. .	1	
	Epidemics and epidemic control .. .. .	1	
	Public health administration .. .. .	1	
<b>D. Statistics.</b>			
	General statistics, mean, standard deviation, rates, etc. .. .. .	7	14
<b>E. Application.</b>			
	Hydraulics .. .. .	5	15
	Water supply and purification, design, etc. .. .. .	10	30
	Latrines, sewerage, sewage disposal, drainage, refuse disposal, plumbing .. .. .	10	30
	Food and milk preservation, transport, handling, restaurants, markets, slaughter houses, etc. .. .. .	3	9
	Town planning, zoning, housing, lighting, ventilation, dust control, factories, etc. .. .. .	4	8
	Malaria control .. .. .	6	12
	Rat control, fly control, rural sanitation, fairs and festivals, disinfection, etc. .. .. .	5	10
		85	185

At the end of 3 months theoretical instruction, an examination will be held consisting of 2 written papers (one for parts A, B, C, D and the other for part E) and a practical test. The candidates who pass these will proceed to their practical training and report on it. If their work is satisfactory and their report shows capacity to deal with the problems that may face them, they may be awarded a "Certificate in public health engineering".

## APPENDIX 36.

*Curriculum of Studies for Sanitary Inspectors.*

Subject.	Hours.
<b>I.—Introductory.</b>	
Scope of public health, sanitation, hygiene .. .. .	1
Evolution of public health—modern public health methods .. .. .	1
Duties and obligations of a sanitary inspector—attributes essential for success .. .. .	1
<b>II.—Elementary physiology .. .. .</b>	<b>8</b>
Personal hygiene .. .. .	2
<b>III.—Communicable diseases.</b>	
Infection, modes of transmission, channels of infection, incubation period; quarantine, contacts, carriers; missed cases, preventive measure ..	
Information about epidemics—Investigation, isolation, surveillance, disinfection.	
Epidemic and endemic diseases .. .. .	1
Smallpox, vaccination .. .. .	2
Cholera, inoculation .. .. .	2
Typhoid, dysentery .. .. .	2
Chickenpox, measles, mumps, whooping cough, diphtheria .. .. .	2
Hookworm and hookworm treatment .. .. .	2
Malaria .. .. .	2
Leprosy, syphilis .. .. .	1
Management of an outbreak of infectious diseases .. .. .	1
Taking of specimens for bacteriological examination in plague, cholera, typhoid, rabies .. .. .	1
<b>IV.—Animals, insects, etc., carrying disease.</b>	
Mosquitoes, anopheles.	
Flies.	
Rats and fleas.	
Bed bugs, lice .. .. .	4
<b>V.—Disinfection and disinfection.</b>	
Water supplies.	
Concurrent and terminal disinfection in infectious diseases .. .. .	3
Fumigation in plague work.	
<b>VI.—Surveying and levelling and drawing.</b>	
Chain survey, plane table, field sketching.	
Levelling, drainage.	
Drawing plans, sections, scales, enlargement reduction, reproduction ..	4
<b>VII.—Building construction.</b>	
Building materials.	
Building construction.	
Village and town planning.	
Estimating.	
Execution of works.	
Type plans.	
Ventilation, lighting, etc. .. .. .	8
<b>VIII.—Water supply.</b>	
Sources, conservation.	
Sinking of wells and tube wells, repairs.	
Purification—settlement, filtration, disinfection. .. .. .	6
Collection of samples.	11A



*Curriculum of Studies for Sanitary Inspectors—contd.*

Subject.	Hours.
<b>IX.—Collection and disposal of excreta and refuse.</b>	
Latrines—different types.	
Soakage pits, urinals, catch pits.	
Septic tanks and title fields.	
Manure pits. Trenching.	
Refuse collection, organisation and methods.	
Composting, dumping .. .. .	7
<b>X.—Disposal of the dead .. .. .</b>	<b>1</b>
<b>XI.—Collection of vital statistics.</b>	
Machinery, population, census, rates, tabulation, infant mortality rates	4
<b>XII.—Food and milk sanitation.</b>	
Nutrition.	
Milk, dairies, slaughter houses, markets, sampling of food and milk ..	8
<b>XIII.—Fairs and festivals ; sarais, dharmasalas, Layout, water supply, latrines, refuse collection and disposal, control of animals and food establishments, control of communicable diseases, accommodation, cleaning up at end of festival, police.</b>	
Sarais, dharmasalas, choultries .. .. .	3
<b>XIV.—School sanitation .. .. .</b>	<b>1</b>
<b>XV.—Public Health Administration.</b>	
Local and provincial set up.	
Relations with other departments .. .. .	2
<b>XVI.—Public health laws .. .. .</b>	<b>6</b>
<b>XVII.—Health Education methods.</b>	
Their importance in rural work.	
Personal contact, discussions, village and school talks, lantern, cinema, leaflets, press articles, exhibitions and type plans and models.	
School health procedures .. .. .	4
<b>XVIII.—Health Unit work .. .. .</b>	<b>3</b>
<b>XIX.—Malaria control.</b>	
Minor drainage and filling.	
Larval control by oiling and parisgreen.	
Adult spray killing.	
Malaria and irrigation.	
Naturalistic methods .. .. .	4
<b>XX.—Office routine .. .. .</b>	<b>2</b>
<b>XXI.—Methods of inspection and carrying out of Sanitary surveys.</b>	
Rural latrines, trenching grounds, wells, markets, slaughterhouses, offensive trades, camps, water supplies, reporting, carrying out repairs .. .. .	12
<b>XXII.—Maternity and Child Welfare .. .. .</b>	<b>2</b>
<b>XXIII.—Legal procedures.</b>	
Framing charges, evidence, etc. .. .. .	6
<b>XXIV.—Sewerage and sewage disposal, plumbing .. .. .</b>	<b>6</b>
<b>XXV.—Offensive trades, industrial hygiene .. .. .</b>	<b>2</b>
<b>XXVI.—Ventilation, atmospheric pollution .. .. .</b>	<b>3</b>
Seminars, tests, etc. .. .. .	10
<b>Total .. .. .</b>	<b>140</b>

*Demonstrations and Exercises as Detailed.*

	Hours.
1. Bucket latrine .. .. .	4
2. Deep pit latrine .. .. .	
3. Bored hole latrine .. .. .	
4. Mound latrine .. .. .	
5. Water seal plate latrine .. .. .	
6. Public latrine .. .. .	
7. Squatting plates .. .. .	
8. Urinals .. .. .	
9. Septic tanks .. .. .	
10. Markets .. .. .	1
11. Meat stalls .. .. .	
12. Dairies .. .. .	
13. Gala cartstand .. .. .	2
14. Slaughter house .. .. .	2
15. Offensive trades, Lime kiln .. .. .	1
16. Tanneries .. .. .	1
17. Wells, tube wells .. .. .	3
18. Disinfection of wells .. .. .	4
19. Disinfection of tanks .. .. .	
20. Chlorination of water .. .. .	2
21. Trenching ground .. .. .	2
22. Catch pits and sealed pits .. .. .	1
23. Compost making .. .. .	1
24. Refuse destructor .. .. .	3
25. Camp incinerators .. .. .	2
26. Water sample for analysis .. .. .	
27. Milk sample for analysis .. .. .	1
28. Hookworm treatment .. .. .	2
29. Vaccination against smallpox .. .. .	4
30. Vaccination against typhoid and cholera .. .. .	4
31. Widal test .. .. .	1
32. Preparation of vaccine .. .. .	2
33. Pasteur treatment and despatch and examination of brain for rabies in dogs .. .. .	2
34. Housing .. .. .	4
35. Disinfection of a house .. .. .	
36. Insanitary and obstructive buildings .. .. .	1
37. Aerated water factories .. .. .	
38. Barbers' shop .. .. .	1
39. Laundries .. .. .	1
40. Maternity and child welfare clinics .. .. .	2
41. Visit to health museum .. .. .	4
42. Infectious disease hospital .. .. .	4
43. Leprosy clinic .. .. .	1
44. Blood for malaria .. .. .	1
45. Specimens of faeces for hook worm infection .. .. .	1
46. Dissection of rats for plague .. .. .	1
47. Antimalaria measures .. .. .	6
48. Cemetery .. .. .	1
49. Sewage farm .. .. .	2
50. Sanitary Assistant's office .. .. .	3
51. M. O. H.'s office .. .. .	
52. Midwife's office .. .. .	1
53. Birth and death registration .. .. .	2
54. Tabulation of vital statistics .. .. .	2
55. School sanitation .. .. .	1
56. Health education procedure .. .. .	6
57. Mosquito surveys .. .. .	3
58. Calcid fumigation .. .. .	3
59. Office routine .. .. .	2
60. Court procedure .. .. .	3
61. Water purification plant .. .. .	6
62. Fairs and festivals .. .. .	6

*Exercises.*

	Hours.
1. Construction of squatting plate .. .. .	10
2. „ pit latrine .. .. .	2
3. „ borehole latrine .. .. .	7
4. „ bucket latrine .. .. .	5
5. „ sealed pits .. .. .	2
6. „ catch pits .. .. .	3
7. „ water seal latrine .. .. .	6
8. „ public latrine .. .. .	2
9. „ urinals .. .. .	
10. „ wells } .. .. .	14
11. „ tube wells } .. .. .	
12. Disinfection of water and test for efficiency .. .. .	6
13. Sanitary inspection of eating house .. .. .	2
14. Bakeries .. .. .	2
15. Markets .. .. .	2
16. Meat stalls .. .. .	2
17. Fish stalls .. .. .	2
18. Dairies .. .. .	2
19. Cartstands and shandies .. .. .	2
20. Grain stores .. .. .	2
21. Slaughter houses .. .. .	2
22. Offensive trades : Tanneries, Lime kiln and Brick kilns .. .. .	6
23. Laundries .. .. .	1
24. Trenching ground .. .. .	2
25. Compost making .. .. .	6
26. Manure pits .. .. .	2
27. Incinerator .. .. .	6
28. Water sample for analysis .. .. .	12
29. Milk sample for analysis .. .. .	2
30. Preparation for mass Hookworm treatment .. .. .	3
31. Technique of vaccination against smallpox .. .. .	30
32. Technique of vaccination against cholera .. .. .	30
33. Blood for widal .. .. .	4
34. Sample of dog's brain for examination for rabies .. .. .	4
35. Housing with regard to Housing laws .. .. .	8
36. Cooly lines and temporary labour camps .. .. .	6
37. Disinfection of a house and articles within .. .. .	4
38. Insanitary buildings .. .. .	4
39. Obstructive buildings .. .. .	4
40. Barber's shop .. .. .	2
41. Aerated water factories .. .. .	2
42. Health centres .. .. .	4
43. Leprosy clinic .. .. .	2
44. Taking blood samples for malaria .. .. .	6
45. Taking specimen of faeces for examination .. .. .	4
46. Rat dissection .. .. .	4
47. Cemetery and cremation ground .. .. .	4
48. Sewage farm .. .. .	4
49. School health survey .. .. .	2
50. Health Survey of village, sarais, dharamsalas .. .. .	3
51. Mosquito larval survey .. .. .	4
52. Court procedure .. .. .	3
53. Plumbing .. .. .	4
54. Water supplies, chlorination testing, etc. .. .. .	8
55. Sewerage .. .. .	8
56. Sewage disposal—several types .. .. .	12
57. Court procedure .. .. .	9
58. Food samples .. .. .	2
59. Smoke and other nuisances } .. .. .	
60. Inspection of factories } .. .. .	6
61. Restaurants .. .. .	2

*Exercises—contd.*

							<i>Hours.</i>
62. Street cleansing	}	..	..	..	..	..	6
63. Refuse collection in towns		..	..	..	..	..	18
64. Sanitary survey of slums, houses, water supplies		..	..	..	..	..	18
65. Plans and drawings	..	..	..	..	..	..	6
66. Enlargement and reduction	..	..	..	..	..	..	6
67. Sketching	..	..	..	..	..	..	6
68. Estimating	..	..	..	..	..	..	18
69. Surveying	..	..	..	..	..	..	12
70. Field sketching	..	..	..	..	..	..	6
71. Building construction	..	..	..	..	..	..	18
72. Malaria control and drainage	..	..	..	..	..	..	
<b>Total</b>							<b>419</b>



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## APPENDIX 37.

*Syllabus for Preliminary Training Course for Nurses.*

Age for admission to be not less than 17 years.

The best education available at any stage of development in a country is the only standard that should be accepted for nursing. A lack of educated girls, however, is only part of the problem, the real problem is how to attract the best there are at level of education available. The best educated and most intelligent will be attracted to the nursing course in proportion to its immediate interest, and to its future opportunities for remunerative work, in a profession of good standing in the community. The nursing course can be made of interest only if it is carefully correlated with the existing educational backgrounds of the students, and realistically linked to community and home conditions, and also presented in a sympathetic atmosphere of student—teacher relationship throughout the course rather than in an atmosphere of reproof to an ignorant and unskilled employee. With such safeguards, despite low standards of education and correspondingly simple professional training, the best students available at the time will be attracted and will make a real contribution to the Health Services in hospital and in the community.

The basic preliminary course (syllabus given) is intended to incorporate these ideas and instil a preventive approach to health from the commencement. Furthermore, this basic course so planned will provide those students who do not continue through the full professional course, valuable experience, immediately applicable to take back with them to their own homes and villages, and will likewise make them influential in increasing the number of desirable applicants for instruction.

**Length of Course.**—The course should not be less than 14 weeks—13 weeks for studies and 1 week for examination. This permits of 3 sessions annually, allowing 10 weeks for transfers and admission of students, and holidays for teaching staffs.

**Hours.**—Approximate hours per week 34, allowing for Saturday afternoon and Sunday free.

**Staff.**—It is suggested that the Sister Tutor in charge of this School should hold the necessary qualification for teaching in addition to Certificate of General Nursing.

■ If the number of students demand an assistant tutor, the minimum qualification of such assistant should be Registered Nurse with practical experience in hospital and ward administration and capable of contributing her full share to the general work of the School.

*Salaries for teaching staff—*

Senior Sister Tutor—Rs. 200—10—250 p.m.

Assistant Sister Tutor—Rs. 150—5—200

and in addition both should receive—free furnished accommodation, messing, uniform and dhobi allowance and service.

Lectures.

Hours.

Practical Demonstration.

**Group :**

I. Elementary Anatomy and physiology  
Elementary Biology

35

Study Class and Laboratory work

80

Lectures	Hours	Practical Demonstration	
<b>Group.</b>			
<b>II. Introduction to Preventive Medicine—Personal and Environmental Hygiene—Principles and Practice of Health Teaching. Introduction to General Psychology .. ..</b>	20	Students Health Examinations Records—Visits to Water works— Sewage Farms—demonstrations of samples of disinfectants—Ele- mentary Bacteriology—In-ocula- tion—Vaccination, etc.	40
<b>III .. ..</b>	..	Physics and Chemistry .. ..	10
<b>IV. Elementary Dietetics ..</b>	20	Practical cookery—Diets for Health adults and children .. ..	26
<b>V. Nursing—1st year group lec- tures, including simple nursing procedures—First Aid—Home Nursing Bandaging .. ..</b>	30	Bed making—Bathing of patients. Taking Temperatures—Pulse, Respiration—Writing up charts— Noting record of cases—General Methods of cleaning wards, Equip- ment, etc., Preparation for simple nursing procedures—Preparation and method of giving enema to adults and children. Administra- tion of medicine. Supervised visits to hospital—wards ..	100
<b>VI. Elementary Economics &amp; Social Science. Social Service —Different types of (a) Commu- nity Organisations—Societies— Institutions, General and Social Hospitals. (b) The family ..</b>	15	Visits to Bustees, village homes & markets—Town markets—Dairies —Co-operative Societies—Labourers Tenements—Middle Class Flats— Orphanages—Voluntary Social Agencies .. ..	40
<b>VII. Physical Culture .. ..</b>	..	Gymnastics—Team games, Folk dances, etc. .. ..	13
<b>VIII. Child Development—Care of</b>	8	Visits to Infant Welfare Centres & Schools—prevention of blindness in new born .. ..	10
<b>IX. Elementary Domestic Science including needle work—Laund- ry— Gardening, vegetables, fruit, flowers, etc. .. ..</b>	15	In the Class .. .. In the Garden .. ..	13 13
<b>Total ..</b>	<b>143</b>	<b>Total ..</b>	<b>265</b>

## MICROBIOLOGY, (INCLUDED IN ELEMENTARY BACTERIOLOGY.

(Group II of Preliminary Training School Syllabus Attached).

### Unit 1.

Micro-organisms and their relation to man  
—helpful & harmful.

Yeast and moulds—seere formation, biological activity; requirements for life and growth importance to man in food production, industry medicines such as ergot, etc.

Bacteria, reproduction, biological activity; destruction; general picture of bacteria in the normal healthy human body, basis of classification, staining and identifications, Disease production; the effect of the bacteria and their toxins on the body.

### Unit 2.

Where pathogenic organisms are found and how infection is spread.

Sources of infection in dirt, water, food, air on body discharges.

### Unit 1.

Introduction to the use of the microscope—examination of simple objects easy to see such as a drop of milk, salt, crystal, hair, etc.

Examination of prepared slides of yeasts, moulds, and bacteria of different varieties.

Note books to be kept and drawing to be made of each slide examined.

### Unit 2.

Examinations under the microscope of fly's leg, village water supply, culture made by student, breathing on media, touching media, throat and mouth culture, from members of the class.

Modes of transfer—direct—drop carriers, human, insect, animals, air borne,

(If possible simple demonstrations of this kind to be shown to hospital in-patients and relatives by students and health teaching given.)

*Unit 3.*

Control and destruction of micro-organisms. The effect of the environment on the life of micro-organisms. Moisture, food, temperature, light, Oxygen.

Disinfection, sterilization, fumigation, senasis, anteseptis and asepsis, their use in the hospital and in the home. Stress on the dangers and results of carelessness.

*Unit 3.*

Simple experiments to show the effect of common physical and chemical agents on micro-organisms, such as sunlight, heat, cold, drying, iodine, alcohol, etc.

Tests for sterility of things which have been sterilized and kept.



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## APPENDIX 38.

## SYLLABUS FOR THE JUNIOR NURSING CERTIFICATE.

*Length of course 3 years, age for admission 17 years.*

40 Lectures & Lecture demonstrations to be given by a certificated nursing sister. Institutional & Domiciliary methods should be taught through the entire course.

Revision classes during first year for students who have passed through the P.T.B. Full lectures for other students.

Hospital Ethics—Etiquette Qualifications essential to the making of a good nurse. Maintenance of health, uniform, General rules of the hospital and nurses home.

The ward its cleanliness, brightness, tidiness, ventilation, care of lavatories, bathrooms, sluice-rooms, utensils—their care and cleanliness.

Hospital equipment—its cost, care, Dressings,—Kinds, uses, costs. Rubber appliances—care and preservation of mackintoshes. Air and Water beds. Hot water bottles—care, filling, precautions, Linen—care of, checking, Inventories.

Bed—beddings, care, disinfection. Bed making. Type of beds. Changing of linen—methods. Nursing positions. Lifting of patients. Giving of bed-pans, etc.

Patients—admission—how to receive. Preparation for stretcher case. Fractures. Collapse. Hæmorrhage—Fits. Removal of clothing. Observations to be made while admitting a patient. Last offices.

Baths—on the bed—in the bath-room—preparations. Cases that should not be bathed without permission. Care and cleanliness of the hair.

Bath-medicated. Hot Air-vapour. Surgical bathspacks, hot and cold Sponging-hot, tepid, cold.

Administration of drugs and how to give simple medicines.

Observation of urine, stools, sputum, vomit, discharges. Specimens—saving of Excreta—disinfection and disposal.

Temperature—pulse—respiration. Clinical Thermometer.

Care of the mouth. Care of the back-bedsore.

Enemata—kinds—requisites—methods of administration.

Applications. Heat, moist and dry—cold iced. Icecaps fomentations—simple—medical surgical. Poultices—Linseed—mustard—charcoal—bread. Evaporating lotions—Counter irritants. Blisters, Leeches. Cupping—wet and dry.

Bandaging—12 demonstrations.

Sickroom Cookery—Theory & practical demonstrations. 15 hours.

Food—contamination—preservation. Milk—composition—dilution—care of—contamination—adulteration. Food values.

Preparing of trays—serving of meals—feeding of patients. Infants feeding.

Predigested food—making—value—uses of. Bengers food—Meat Extracts. Peptonised milk—whey—junket. Jelly—Albumin water.



Eggs—fish. Methods of preparing—cooking—serving. Vegetables—fruit—method of preparing—cooking—serving. Child—care of—diet for healthy and sick.

Special diets.

Hygiene Lectures & Demonstrations. 20 Hrs. to be given by a Doctor, preferably with Public Health experience.

Personal hygiene—aids to health—habits—fresh air. Cleanliness. Exercise—food—rest—clothing.

Atmosphere—Atmospheric-Pressure, composition of air, various impurities. Heat radiation—Conduction—convection—Body Heat, evaporation.

Ventilation in health and disease. Light—natural and artificial.

Water—sources of drinking water—rain—springs—rivers—wells.

Distribution of water—mains service pipes—head pipes—cisterns. Purification—pollution—storage—filtration—chemicals. Ozonisation ultra-violet rays.

Refuse—collection—removal—disposal.

House and Hospital—Water carriage system—Conservancy.

System—sewage system. Disposal—purification of sewage.

Drainage system—traps—soil pipe—water pipe.

Sanitary conveniences and appliances—water closets—sinks—baths—basins.

Infection—disinfection—methods.

The part played by the agency of water—food—air in the tropical diseases, such as cholera, dysentery, the enteric group of fever. Pneumonia—plague.

Personal and General prophylaxis.

The part played in tropical diseases by insects such as lice, bed bugs, fleas—sand flies—mosquitoes—worms and other intestine parasites.

Personal and General Prophylaxis.

Anatomy and Physiology. 30 lectures and demonstrations.

To be given by a Doctor. Revision lectures by Sister Tutor.

The bony skeleton—names of bones—types—position in the body.

Classification of bones—composition—structure—joints—varieties etc.

The muscular system—voluntary and involuntary. Difference in their mode of action. Position of the chief muscles in the body. Anatomy of the thorax and abdomen.

The lungs and their passages. The heart—the circulation of the blood.

Structure of the chief blood and lymphatic system.

The mouth—teeth—intestinal tract.

Classes of foodstuffs—fats—carbohydrates—proteins—absorption of food products.

The skin—sweet glands—hair—nails, the urinary system.

The nervous system.

Reproductive organs.

Special senses.

Ductless glands.

*Lectures on Medical Diseases.*—20 Lectures to be given by a Doctor in addition—20 lectures on nursing care in each disease to be given by the sister tutor, in co-ordination with the Doctor's lectures. Institutional & Domiciliary methods should be considered.

The cause of disease and human pathology.

Alimentary system ; the more important diseases and their chief symptoms.

Respiratory system ; cough, breathing in disease. The more important diseases and their symptoms.

Tuberculosis : symptoms, cause, disposal of sputum, sanatorium treatment, light, air, food prevention.

Circulatory diseases ; the more important diseases and their symptoms. Heart disease, Rheumatism, Cholera.

Excretory system : urine in disease. Chief diseases of the kidney and their symptoms. Diabetes.

Central nervous system. Chief diseases and symptoms. Convulsions, fits.

Natural and artificial protection against disease. Immunity, inoculation and vaccination. Bacteriology.

Infectious diseases ; smallpox, Enteric, Dysentery, Measles. Chicken-pox, Whooping cough, Diphtheria.

Isolation and disinfection of—

Introduction ; malaria, black water, relapsing fever.

Kala azar, plague, leprosy.

Beri beri, scurvy, pellagra.

Cholera, dysentery, hepatitis.

Sprue, ankylostomiasis, filariasis.

Snake bite, hydrophobia, heat stroke.

Diet in disease. Pre-digestion of foods, Special diets.

Nutrient enemata. Proprietary preparations, their uses and dangers. Deficiency diseases.

Medical emergencies, fainting, syncope, epileptic fits, convulsions, bleeding, colic, etc.

*Drugs and Poisons.*—Drugs and remedies. Their sources, nature, classes, method of use, common poisons, symptoms and treatment.

*Lectures on Surgical Diseases.*—20 lectures to be given by a Doctor in addition—20 Lectures on Nursing care by Sister Tutor in co-ordination with the Doctor's lectures.

Micro organism ; infection ; inflammation, suppuration, cellulitis. Tetanus, tuberculosis, etc.

Principles of asepsis ; antiseptics, sterilization, influence of atmospheric pressure, of boiling water and steam.

Haemorrhage, varieties of, first aid and surgical treatment.

Preparation of patients for operation. Duties of nurse in the operation theatre. Operations in private houses.

Injuries, shock, contusions, wounds varieties and processes of healing, Complications, treatment.

**Burns and scalds.** Ulceration ; gangrene, tumour, cancer of breast.

**Fractures and dislocation, including first aid treatment, Orthopaedic Surgery, Causes of deformity.**

**Diseases of bones and joints. Use of splints. Head and spine injuries. Operations on the mouth. Empyema.**

**Abdominal surgery ; gastric and duodenal ulcer, gastric gall stones, appendicitis. Intestinal obstruction, etc.**

**Caecostomy and colostomy. Hernia, varieties, complications operations for.**

**Common diseases of rectum and anus. Istula, haemorrhoids carcinoma, Diseases of urinary system, Prostate, Care of patients after operation.**

**Anaesthetics :—Short account of action of general and local anaesthetics. Common anaesthetics. Preparations of anaesthetics table. Preparation of patients for general anaesthesia. Management while under general anaesthetic. Methods of artificial respiration. Care of patients during recovery. Treatment of the after effects of anaesthesia.**

**Gynaecology.—12 lectures to be given by a Doctor.**

**Structure and functions of the ovaries, Fallopian tubes, uterus vagina. Disorders of menstruation and menopause. Vaginal discharges, New growths of ovaries and uterus.**

**Preparation of patients for examination. Douche.**

**Thampons, Plugs, Pessaries.**

**Nursing after major and minor operations.**

**Nursing of cases of Eye Diseases—6 lectures.**

**Anatomy and physiology briefly.**

**Instruments for examination. Foreign bodies, discharge from the ear, How to syringe ? Use of dry heat in acute inflammation of ear. Application of fomentations. Application of heat and cold. (Lieters coils). Application of leeches, blisters, etc., over the mastoid process, ear drops. Dressing after ear operations. Brief description of anatomy and physiology of the nose, Pharynx and larynx. Hygiene of the mouth with reference to the disease of the nose-pharynx and larynx ; spraying and couching. Haemorrhage from the nose and throat. Nasal discharges. Obstructions, to breathing and swallowing. Gargles mouth washes. Inhalations. How to paint the throat instruments for operations. Tonsils and adenoids. Abscess of throat. Tracheotomy. Administration of food in painful diseases of, and after operations on the throat.**

**Skin diseases—6 lectures.**

**Skin, anatomy and physiology. Application of remedies. Lotions, liniments, ointments, pastes, powders, Common diseases, boils, ring-worm, itch, eczema, psoriasis, secondary infections. Cleansing of skin, Removal of rusts.**

**Venereal Diseases—6 lectures.**

**Syphilis and Gonorrhoea.**

**A brief account of causes—mode of infection—signs & symptoms.**

**Prophylaxis**—general rules regarding infectivity and modes of transmission of venereal diseases and their prevention.

**Nursing Care** of patients of venereal diseases.

**Knowledge** of sterilization ; of syringes.

**Principles** of dressing syphilitic wounds.

**Care** of eye and urethra in Gonorrhoea.

**Urethral douches.**

**Prostatic massage.** For male nurses.

**Making** of smears.

*Nursing of children—20 hours.*

(10 lectures by a doctor and 10 lectures by the Sister Tutor).

The development of a normal child—health requirements. General principles of infant feeding—the feeding of children up to 2 years.

The observation of children in health and sickness, cries, stools, attitude of the child, symptoms, etc.

The nursing of children including the giving of medicines—treatments—feeding and occupational therapy.

**Special diseases** of children.



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## APPENDIX 39.

## SYLLABUS FOR THE SENIOR NURSING CERTIFICATE.

*Length of course—3 years.**History of Nursing and Ethics.*—20 Hours—In 1st Year, after the P.T.S. (Revision).

Unit I.—The pre-Christian period—ideas of disease in the primitive world and resulting methods of treatment—medicine in ancient India, China, Egypt, Greece, Rome.

Unit II.—Nursing in the early Christian era—the deaconesses, the Roman matrons Monasticism, the development of hospitals.

Unit III.—Aristocratic and Military Influences—the influence of Feudalism—the knights and ladies of St. John of Jerusalem, of St. Lazarus, etc.

Unit IV.—Democratic and Secular Tendencies in Medical Nursing orders, Social and economic changes following the crusades ; St. Francis of Assisi and his Orders—St. Claire and the poor Claires, the Beguines.

Unit V.—Transition from Medieval to Modern era—Political, social and economic changes as a background of the period. The closing of monasteries—the extension of the servant nurse system.

Unit VI.—Pre-Nightingale Reformers :—

St. Vincent de Paul and Milee. Le Gras John Howard, Elizabeth Fry, the work of the Fleidners at Kaisersworth.

Unit VII.—Florence Nightingale—Her life, her work in the Crimean War, the founding of the Nursing School at St. Thomas Hospital. Her interest in India and Reforms.

Unit VIII.—Contemporary developments—the discoveries of Pasteur, Lister Kock, etc. The relationship of Nursing to hospital reform.

Unit IX.—Nursing in India in the modern days—the introduction and growth of Nursing in India—development of schools—examination and registration—a brief review of nursing organisations in India, today.

Unit X.—The Public Health Nurse—the story of her development in various countries and the need of such nurses in India.

Unit XI.—The contribution of the nurse of today to the History of Nursing—the responsibility of the nursing student to her profession—her heritage and opportunities.

*First Year after the P.T.S.*

*Advanced Nursing Arts.*—2 hours 3 times a week for 34 weeks, 102 hours.

Unit 1.—Collecting and sending specimens—Urine, stool, sputum, cerebro-spinal fluid (lumbar puncture, cernal puncture) blood, kidney function tests—gastric analysis, abdominal paracentesis, etc.

Unit 2.—Providing the patients with a healthy environment both physical and mental, the patient's comfort and safety, supportive nursing measures. The uses of appliances, back rests, cradles, air rings, pillows, sand bags, knee pillows, fracture board, bradford frame, backing frame. Positions, lifting and turning the patient. Use of the wheel chair, heart table, etc.

Unit 3.—Pre-operative and post-operative nursing care.

Unit 4.—Giving of fluids and drugs by rectal drip-hypodermoclysis, and intravenous methods. Techniques used in the hospital and in the home.

**Unit 5.—Planning the nursing care to provide for the patients' individual needs.**

**Unit 6.—Recognising and providing for the need of health teaching to patients and relatives ; answering patients' questions, giving explanations of hygiene and requirements of healthy living, demonstrating nursing care and medical treatment the patient will need after discharge. Teaching the adaptation of the principles of health to the patients way of living.**

**Unit 7.—Therapeutic treatments.** In each case ways of winning the patients cooperation and methods used in the home should be included. **Surgical dressing, care of plaster casts, counter irritants, hot and cold applications. Packs, sponges, inhalations. Hot air and steam tents irrigation and douches. The administration of oxygen, all important therapeutic techniques.**

**Unit 8.—Care of the dead.**

**Unit 9.—Nursing techniques used in diseases of the eye, ear, nose and throat.**

**Unit 10.—Nursing techniques adapted to the nursing of infants and children.**

*Combined course to run through the 2nd Year—190 Hrs.*

This course should bring together into one course the pathology, medicine and medical nursing, surgery and surgical nursing, materia medica, diet and the public health knowledge each nurse needs as a foundation for her work in the hospital or in the home. An attempt is made to arrange the material in good psychological order and integrate it into a unit. The medical and surgical lectures should be given by doctors and followed by the Sisters Tutors' lecture giving the special nursing care in the conditions considered. The principles underlying good nursing care in each case should be applied to conditions in the hospital and in the homes. Stress should be placed on health teaching and prevention of disease throughout the course by the Sister Tutor and the doctors. The materia medica and diet therapy should be related to conditions studied.

**Unit I.—Introduction to Medical and Surgical Nursing :—**

The effect of disease on the body—tissue changes, inflammatory processes, infections—general and local—hemorrhage, embolism and shock.

**Unit II.—Operative Aseptic Technique :—**

Asepsis, general principles, surgical cleanliness, sterilization by Heat, by antiseptics.

Preparation of patient for operation. Post operative care. Operation Theatre—

Preparation of operating Theatre, lighting, heating, ventilation, equipment, instruments in common use. Operative procedures—nurses duties.

Preparation for operation in private house—Anaesthetics, general spinal and local anaesthetics in common use, their general character.

Special Nursing care of cases given anaesthetics.

**Unit III.—Nursing in diseases of the respiratory system :—**

1. Medical aspects of diseases of the sinuses, tonsils, larynx, trachea and bronchi.

2. Surgery of the same including bronchoscopy.

3. Nursing care in those conditions.

4. Diseases of the lungs—Pneumonias, lung abscess, pulmonary emphysema, pulmonary tuberculosis.

5. Operation on the lungs and for conditions of the lung—lobectomy rib resections—drainage of lung abscess.

6. Nursing care in the above with special stress on health teaching position—use of special equipment—slings—sand bags—care of drainage suction, etc.

Unit IV.—Nursing in diseases of the circulatory system and :—

1. Heart diseases, myocarditis, endocarditis and valvular diseases pathology, symptoms, treatment.

2. Nursing care in heart disease.

3. Blood transfusion—indication, various types, use of plasma, dry blood, etc.

4. Diseases of the blood and lymphatics, anaemias, Raynauds, Buerger's and Hodgkin's disease.

Unit V.—Disease of the Gastro intestinal system :—

1. Diseases of the mouth, throat and stomach.

2. Surgery in structure of the esophagus, gastric ulcer, malignant tumours of the stomach.

3. Special nursing care in such cases—Health teaching necessary for such cases.

4. Diseases of the intestinal tract, typhoid, dysenterys.

5. Surgery of the intestinal tract—intestinal obstructions, appendicitis, hernia, resection, etc.

6. Nursing care in diseases and operations on the intestinal tract.

7. Operations on the colon, rectum and anus.

8. Nursing care in the same.

Unit VI.—Conditions of the urinary tract :—

1. Diseases of the kidney, urethra, bladder.

2. Operations on the urinary tract.

3. Nursing care in the above—including an understanding of kidney function tests, special treatments, etc.

Unit VII.—Conditions of the musculo skeletal system :—

1. Fractures, dislocations, sprains and their treatment.

2. Diseases of the bones and joints, acute and chronic arthritis, rheumatic fever.

3. Tuberculosis of the bone and joints—deformities, and operations done.

4. Nursing care in orthopaedic Diseases—including special points regarding traction, frames, splints and plaster—helping the patient with his problems of rehabilitation and the care of orthopaedic cases in the home.

Unit VIII.—Diseases of the skin :—

1. Diseases of the skin and their medical treatment.

2. Burns, scalds, skin grafting, Plastic operations.

3. Nursing care in skin conditions.

**Unit IX.—Conditions affecting the muscular system :—**

1. Tumours benign and malignant with stress on early attention.
2. Nursing care—health teaching every nurse should do.

**Unit X.—Conditions of the endocrine glands and metabolism :—**

1. Thyroid conditions, diabetes.
2. Surgery in Thyroid conditions.
3. Nursing care in such cases with special reference to teaching the patient and his relatives.

**Unit XI.—Conditions of the nervous system :—**

1. Chorea, epilepsy, general paresis, tabes dorsalis, neuritis, sciatica, etc.
2. Operations on the brain and spinal cord.
3. Nursing in the above.

**Unit XII.—Gynaecological and Genito-urinary conditions :—**

1. Hygiene and health of sex-life with special reference to the psychological aspects.
2. Gynaecological conditions and medical treatment.
3. Surgical treatment of gynaecological conditions.
4. Nursing care in the above.
5. Medical aspects of genito-urinary disease.
6. Surgery of the genito-urinary tract.
7. Nursing care in conditions of the genito-urinary tract.

**Unit XIII.—Conditions of the eye, ear and nose :—**

1. Eye health.
2. Diseases of the eye—medical and surgical treatment.
3. Nursing care in eye conditions.
4. Disease of the nose and ear including the prevention of deafness.
5. Nursing care in the above.

**Unit XIV.—Deficiency diseases :—**

1. Deficiency diseases—their prevalence in India, early symptoms and prevention.
2. The Nurses responsibility in health instruction & nursing care.

**Unit XV.—Tropical diseases :—**

Malaria, black water, relapsing and yellow fever.

Kala azar, plague, leprosy.

Cholera, dysentery, hepatitis.

Sprue, ankylostomiasis, filariasis.

Snake bite, hydrophobia, heat stroke.

2. Nursing care in the hospital and in the home with special stress on health teaching and prevention.

**Unit XV.—Communicable diseases :—**

1. Measles, chickenpox, small-pox, diphtheria, etc.
2. Nursing care in the hospital and in the home with special stress on prevention of spread of the disease and health teaching.
3. Gonorrhoea and syphilis with stress on prevention and control.
4. Nursing care in the above and the nurses responsibility for health teaching.



### THIRD YEAR COURSE.

#### *Nursing of children—20½ hours.*

(10 lectures by a doctor and 10 lectures by the Sister Tutor.)

The development of a normal child—health requirements. General principles of infant feeding—the feeding of children up to 2 years.

The observation of children in health and sickness, cries, stools, attitude of the child—symptoms, etc.

The nursing of children including the giving of medicines—treatments—feeding and occupational therapy.

Special diseases of children.

#### *Mental hygiene—15 hours.*

Mental health and requirements for a well balanced personality. The needs of the individual—types of personality—mental and emotional development—instincts, the subconscious mind—common neurological conditions, causes, preventive measures, sublimation. The problem of mental diseases in the community—practical psychology.

#### *The principles and practice of war and hospital management.—30 hours.*

Ward administration, the principles of supervision, assigning of duties, hospital housekeeping, inventories and ordering equipment and supplies.

The selection of staff—staff education, budgets, records, housing and health of the staff, medical examinations and supervision of the health of the staff, the prevention of diseases, care of sick nurses. Making the best use of resources at hand—a planned programme for improvement. Opportunities for observation and practice of principles taught should be given.

#### *Professional Problems—15 hours.*

The problems and responsibilities of the young graduate—how to apply for a post—contracts—ethical responsibilities—professional opportunities.

Nursing organisations in India—their organisation, aims and work—professional journals—the International Council of Nurses, the Red Cross.

Nursing legislation, registration, what are desirable laws—their purposes. The nurses responsibility for nursing and health legislation. Legal matters.

India's needs in the nursing field—trends and developments in India and other countries.

#### *Health Problems in India to-day—20 hours.*

A consideration of the health problems of the country and attempts that are being made to meet them. Malaria, leprosy, tuberculosis, venereal diseases, maternity and child welfare, school health, industrial health problems. Rural health—economic factors in national health—health education, the need and method—preventive medicine, the responsibility of the nurse. Problems in the local community.

## APPENDIX 40.

## CURRICULUM FOR PRE-NURSING GROUP OF 1 YEAR IN HIGH SCHOOLS IN INDIA.

Subjects.					Taught by.
Anatomy and Physiology	..	..	..	..	Doctor.
Hygiene	..	..	..	..	Doctor.
First Aid	..	..	..	..	Doctor.
Physics & Chemistry & Practical Physiology	..	..	..	..	University Graduate.
Biology	..	..	..	..	Do.
Psychology	..	..	..	..	Do.
Dietetics and practical cookery	..	..	..	..	Do.
English Language & Essay writing	..	..	..	..	Do.
Home Nursing St. John & Red Cross Standard	..	..	..	..	Registered Nurse Instructor.
Mother Craft	..	..	..	..	Do.
History of Nursing	..	..	..	..	Do.

Visits to Institutions, Games and Physical Training.

Examination at the end of course.



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## APPENDIX 41.

## SYLLABUS FOR MIDWIVES TRAINING COURSES.

*Syllabus for Midwives Diploma or Certificate.*

1. The period of professional study between the date of admission as midwife pupil and the date of examination for any diploma or certificate which entitles the holder thereof to be registered in Part I of the register of midwives shall be a period of certified study of not less than 18 months :

Provided that a fully trained nurse shall be admitted to the examination in midwifery after not less than six months training on obstetrics if she can satisfy the requirements of rules 1 and 2 of Part I of this Appendix in all respects other than that of the period spent under training as a midwifery student :

Provided further that for a period of twenty four months from the 24th December, 1935 midwives with twelve months training shall be eligible for registration.

2. In every course of professional study and examination, the following subjects shall be included :—

(i) Gynaecology.—An elementary knowledge of menstruation, abnormalities in menstruation, displacements of the uterus, growths and tumours (cancer) in the pelvis (uterus and adnexa) and inflammatory conditions of the vagina.

(ii) Antenatal care.—The training should include attendance at an antenatal clinic, if possible, or study of antenatal cases. Notes of at least ten of such cases should be written in the case book.

(iii) Midwifery.—(In any scheme of examination for midwives, emphasis should be laid upon the practical aspects of midwifery and the actual conduct of normal and abnormal labours, while the training is given both in theory and the practice of the subject.)

Asepsis and antisepsis in midwifery. Some of the common antiseptics used in midwifery and the way to prepare them. The disinfection of the person's clothing and appliances.

Elementary general physiology and anatomy of the female pelvis and the organs of generation, both external and internal.

Obstetrical diagnosis.

Management of normal pregnancy.

Hygiene of normal pregnancy.

Hygiene and care of the pregnant woman and the unborn child.

Labour and its phenomenon.

Signs and symptoms of abnormal pregnancy.

Management of normal labour.

Diagnosis and management of abnormal presentations face, brow pelvis presentations, transverse presentations, multiple pregnancy.

Care of the puerperium and its management.

Complications of the puerperium including puerperal sepsis and septic infections. Causes, symptoms, diagnosis and methods of treatment.

Haemorrhages of pregnancy antepartum and postpartum.

Toxemias of pregnancy albuminuria, eclampsia hyperemesis.

Abortion, miscarriage and premature labour.

Extrauterine pregnancy.

Precipitate labour, uterine, inertia, rupture of the uterus, causes, symptoms, diagnosis and treatment.

Prolonged labour.

Disease of the decidua and ovum ; hydramnias and vesicular mole.

Contracted pelvis—diagnosis—common varieties—symptoms—treatment.

Diseases associated with puerperium—cystitis—mastitis—phlegmasia—puerperal insanity.

Some common obstetrical operations and the duties of the midwife therein.

Vaginal examination during normal labour under supervision.

(ie) Care of the infant with particular reference to—

Asphyxia neonatorum.

Ophthalmia neonatorum.

Infantile diarrhoea.

Convulsions.

Care of the premature infant.

Management of the new born, both mature and premature.

Breast feeding and artificial feeding.

(v) Venereal diseases :—Syphilis and gonorrhoea with special reference to their effects on the pregnant and parturient woman.

(vi) An elementary knowledge of the following diseases common in the tropics with special reference to their effect on pregnancy labour, and puerperium :—

(1) Malaria.

(2) Kala-Azar.

(3) Smallpox and eruptive fevers.

(4) Typhoids.

(5) Influenza pneumonia, tuberculosis.

(6) Anaemia.

(7) Hook-worm.

(8) Leprosy.

(vii) General principles of sick nursing:—

Nursing as a profession and hospital etiquette.

Work in the ward.

Observation and care of the patient.

Temperature, pulse, respiration, clinical chart and bedside report.

Bed-making and sponging.

Contagion and disinfection.

Catheterisation : bladder and bowel wash.

Enema and douches.

Hot and cold application.

Administration of food and medicine.

Invalid cooking.

Some emergencies.

Care of the dead.

Cold sponging.

Prevention and care of bed-sores.

Different kinds of haemorrhage.

Arrest and treatment of the same.

Personal and surgical hygiene.

No candidate shall be permitted to appear for the examination, unless she produces a certificate to the effect that she has—

- (a) personally attended 20 labour cases,
- (b) nursed twenty lying-in women and their infants during the ten days following labour,
- (c) attended not less than 10 antenatal cases, and
- (d) attended not less than two-thirds of the lectures and demonstrations given in connection with the curriculum laid down.



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## APPENDIX 42

## SYLLABUS FOR TECHNICIANS' COURSE.

*Group I (i.e., Anatomy and Physiology).*

## PART I.

A.—ANATOMY—*Period 6 months.*

1. Elements of Anatomy of the human body with special reference to Osteology.
2. Cleaning and care of bones—preparation of skeletons.
3. Training in the care and uses of different instruments used in the dissection of the human body.
4. Instruments in the preparation of different fluids used as a fixative for the dead body.
5. Record keeping of the stock of the department.
6. Training in making arrangement for a lecture-demonstration.
7. Use of a rough balance.

B.—PHYSIOLOGY—*Period 6 months.*

1. Cleaning of glassware and other pieces of apparatus used.
2. Trained in the operation and care of routine laboratory equipment, such as microscopes, water bath, etc.
3. Staining method, including preparation of simple stains.
4. Handling of Laboratory animals.
5. Preparation of simple reagents.
6. Technique of examination of urine and blood.
7. Use of a rough balance.
8. Preparation of solutions used for qualitative test.
9. Muscle and nerve preparation of frog.
10. Induction coil and their uses.
11. Setting up of B. M. R. and other apparatuses.
12. Maintaining of records, if any.
13. Care and management of experimental animals.
14. Glass blowing.

Examination at the end of one year's course.

Candidates will be given lecture-demonstration by the staff of the department.

## PART II.

A.—ANATOMY—*Period 4 months.*

1. Injections—preservation of dead body.
2. Methods in embalming of the human dead body.
3. Arrangement for the dissection of human body.
4. Care and mounting of specimens for museum.
5. Training in the preparation of part for dissection and the methods used for a nice display of the part.
6. Histological technique—training the Department of Pathology and Physiology if required.

**B.—PRACTICOLOGY—Period 8 months.**

1. Preparations of reagents for volumetric and gravimetric analysis.
  2. Preparation of various fixatives and staining reagents required, in histopathological work.
  3. Use of the microtome.
  4. Embedding tissue, and cutting of section.
  5. Different methods of staining tissue.
  6. Methods employed for killing experimental and other laboratory animals.
  7. Training in setting up of drums and kynograph.
  8. Methods used for microphotograph and the use of Epidiascope, etc.
- Final examination at the end of 2 years.

**COURSE FOR LABORATORY TECHNICIANS.**

*For Group II (i.e., Pathology, Bacteriology and Biochemistry).*

**PART I.**

**ONE YEAR'S COURSE.**

**I.—Preparation and Sterilization of glassware and media.**

- (i) Glassware—Preparation, cleaning and sterilization.
- (ii) Preparation of simple media and combined media, including methods of their sterilization. Care and operation of different types of sterilisers and hot-air ovens.

**II.—General Bacteriological and Parasitological Technique.**

- (i) Training in the operation and care of routine laboratory equipment such as microscope, incubators, water baths and centrifuges, etc.
- (ii) Staining methods including preparation of simple stains.
- (iii) Cultural methods and use of media.
- (iv) Technique of Agglutination tests.
- (v) Disinfection and sterilisation of contaminated material.
- (vi) Handling of laboratory animals.

**III.—Serological Technique.**

- (i) Care of apparatus used in the tests.
  - (ii) Preparation of material for examination.
- IV—Care and Management of Experimental animals.**

**V—Maintenance of records.**

**VI—Clinical Laboratory Methods.**

- (i) Preparation of simple reagents, e.g., Fehling's and Leishman, etc.
- (ii) Staining of smears by routine methods, e.g., Grams, Ziehl-Neilsen.
- (iii) Technique of examination of Urine, Faeces, Sputum, Blood, etc. (Qualitative).

**VII.—Attendance in the Post-Mortem Room.**

- (i) To get acquainted with the use of instruments and render intelligent assistance to the Pathologist.
- (ii) Collection and handling of pathological material received from the hospital and post-mortem room.
- (iii) The candidates will have lecture-demonstrations once a week by one of the medical officers of the department.

### VIII.—*Biochemistry.*

- (i) Cleaning the glassware, calorimeter and other pieces of apparatus used.
- (ii) Preparation for Fractional Test Meal, and for other tests like Kidney Function, Liver Function Tests, etc.
- (iii) Use of a rough balance.
- (iv) Preparation of solutions used for qualitative tests.
- (v) Technique for simple qualitative tests used in routine Biochemical analysis.
- (vi) Setting of apparatus for routine quantitative Biochemical analysis.
- (vii) Setting up of B. M. R. apparatus.

The candidates will have lecture-demonstrations once a week on fundamental principles.

An examination will be held at the end of the whole course.

### PART II.

#### ONE YEAR'S COURSE.

##### I.—*Clinical Laboratory Methods.*

- (a) Instructions in the preparation of different reagents [required in Clinical Laboratory for examination of Urine, Blood, Faeces, Sputum, C.S.F., etc.
- (b) Setting up of apparatus for the various tests.
- (c) Use of microscope.

##### II.—*Histo-Pathology.*

- (a) Preparation of various fixatives and staining reagents used in Histo-Pathological work.
- (b) Use of the microtome.
- (c) Embedding and section-cutting.
- (d) Different methods of staining.

##### III.—*Biochemistry.*

- (a) Use of a Sensative Balance.
- (b) Use and calibration of Volumetric measuring apparatus.
- (c) Preparation of standard Volumetric Solutions and accuracy in Volumetric analysis.
- (d) Principles of Colorimetry and Nephelometry.
- (e) Care and use of micro analytical apparatus.
- (f) Preparation of reagents for routine biochemical analysis.
- (g) Technique of routine quantitative Biochemical analysis of blood. Pathological fluids and concretions.

##### IV.—*Advance Techniques.*

- (a) Preparation of special media.
- (b) Advanced bacteriological and serological technique with special reference to identification of organisms and vaccine manufacture.
- (c) Preparation of reagents and stains.
- (d) Advanced parasitological technique.
- (e) Management, care and handling of experimental animals and technique associated with their use in research.
- (f) Maintenance of records.

Candidates will have lecture demonstration in such subjects as general Bacteriology, Immunity and Elementary Physiology.

Examination will be held at the end of the whole course.



## APPENDIX 43.

## COURSE FOR RADIOGRAPHERS.

## PART I.

*Six months' tuition followed by examination.*

**Elementary Anatomy.**—Skeletal bones—epiphysis in Embryo, in infancy and in adults. Skull with reference to military Fossa, Cranial Fossa, blood vessel grooves fractures; the diploe and Lumbar vertebrae—long and short bones of the extremity.

**Physiology.**—Elementary knowledge of the special organs of the body—Other Brain, spinal cord, lungs and heart, oesophagus, stomach, intestines (large and small), appendix, liver, spleen, pancreas and ductless glands.

**Pathology.**—Lesions of the skull—Diseases of the heart and lungs—Viscerae of abdomen, bony tumours, etc.

## PART II.

*Twelve months' tuition followed by examination.*

Radiography; Radiotherapy and Electrology suitable for Certified Radiological Assistants.

## HISTORY, LECTURES.

**Apparatus.**—Construction, wiring and assembling Valve and X-Ray tubes, types, construction and properties. Care and control of apparatus.

**Radiography.**—Radiographic technique—Care of patients while in the Radiographic Department.

**Dark Room.**—Photography and Dark Room Technique.

**Radium & X-Ray Treatment.**—Superficial and Deep exposures—filters—Radiation Dangers—Care of patients while in the Department.

**Electrology.**—Principles of Electrical, Light and Heat Treatment. Methods of application—Care of patients during treatment.

**Electrocardiography.**—Principle and application of the instrument.

## PART III.

6 months' Practical work in the different sections of an Institute of Department of Radiology.

## APPENDIX 44.

*Extract from a booklet describing the functions of the Registry of Medical Technologists of the American Society of Clinical Pathologists.*

"The Registry of Medical Technologists has established certain standards for workers who desire to follow this vocation, and it conducts examinations for those who meet the qualifications. The Technologist who is certified by the Registry of Medical Technologists is recognized by leading clinical pathologists and well-informed physicians as having adequate qualifications and enjoys a definite professional standing as a result of the Registry's recognition.

The Registry has been so successful in its work that it has become the quasi-official body in this country for certifying the qualifications of laboratory workers. Its work is heartily endorsed by the leading medical and hospital organizations, notably the American Medical Association, the American College of Surgeons, the American Hospital Association, the Catholic Hospital Association, and many others, all of which commend its aims and objectives and recommend to their respective members the acceptance of the Registry certificate as proof of the competence of a Medical Technologist. Staff inspectors of the American Medical Association and American College of Surgeons, in their periodic visits to hospitals, carefully observe whether or not the workers in the clinical laboratories have Registry certificates. The Registry, in brief, while purely voluntary and non-coercive, is universally accepted as the authoritative organ for qualifying the laboratory technicians of the United States and Canada.

The conduct of the Registry is vested in a board of six members, who are elected by the American Society of Clinical Pathologists.

The office of the Registry is conducted by a registrar approved by the Board, who, under the direction of the Chairman and with the aid of clerks, attends to the necessarily voluminous correspondence, routine business, book-keeping, and elaborate filing system required in the management of what has become a truly useful and important institution.

An Advisory Committee of five Medical Technologists aids the Board of Registry in the conduct of its work. Two members of this committee are members of the American Society of Medical Technologists and three are chosen from the registrants who are not members of the American Society of Medical Technologists.

#### *Eligibility.*

Applicants for the Registry examination must have graduated from an accredited high school or have received an equivalent education. In addition, they must have attended a course of at least two years at a college or university accredited by the regional professional college association. In these two years emphasis must have been placed on chemistry and biology.

After the necessary college credits have been acquired, the applicant must have instruction for at least twelve consecutive months in an approved training school for Medical Technologists, or an apprenticeship instruction of at least twelve consecutive months under a qualified clinical pathologist.

#### *Examination of Applicants.*

Applicants who have met the above requirements will be permitted to take the Registry examination. Twice a year, usually in April and October, examinations are conducted in over 100 localities in the United States and Canada. The examinations are in charge of clinical pathologists, usually

members of the American Society of Clinical Pathologists. An effort is made to send applicants to the nearest examiners. Applicants are never assigned to examiners under whom they have been trained, or in whose laboratory they are employed. Under no circumstances are exemptions from the examination allowed.

The examination is divided into two parts :

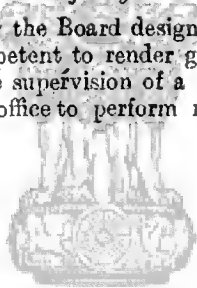
1. A written examination usually consisting of ten questions.
2. An oral and practical examination during which the applicants are asked to carry out under the eye of the examiner or his assistant certain standard laboratory procedures, besides answering questions demonstrating their knowledge in Medical Technology.

The questions for both the oral and written tests are formulated by members of the Board of Registry and sent under seal to each local examiner. The latter then marks the results of the practical test and sends these and the answers to the written test to the registrar, who in turn transmits them to the official examiner. By this method a fair and impartial judgment is reached.

The practical examination and the written examination have equal value, and a passing grade of 70 per cent. must be received in each.

#### *Title of Registrant.*

The certificate issued by the Board designates the holder as a Medical Technologist who is competent to render general technical service in a clinical laboratory under the supervision of a qualified clinical pathologist, or if working in a physician's office to perform routine laboratory tests for his patients."



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## APPENDIX 45.

SCHOOLS FOR OCCUPATIONAL THERAPISTS, PHYSICAL THERAPISTS AND  
CLINICAL LABORATORY TECHNICIANS.

Council on Medical Education and Hospitals.

AMERICAN MEDICAL ASSOCIATION.

*Essentials of an Acceptable School for Clinical Laboratory Technicians.*I.—*Organization.*

1. Acceptable schools for training laboratory technicians may be conducted by universities, colleges, hospitals or public health laboratories.

2. The Council has promulgated standards for this type of training to supply physicians, hospitals and prospective students with reliable information and for the protection of the public.

3. Responsibility for courses in hospitals should be placed on the hospital administration rather than the laboratory director. In colleges and universities this responsibility is on the controlling board, as for other courses.

4. Resources for continued operation of the school should be insured through regular budgets, gifts or endowments but not entirely through students' tuition fees. Experience has shown that commercial schools operated for profit frequently do not adhere to proper ethical and education standards and are, therefore, not acceptable.

5. There must be available transcripts of high school, college work and other credentials. Attendance and grades of students shall be carefully recorded, by means of which an exact knowledge may be obtained regarding each student's work.

6. At least two or more students should be enrolled in each class.

II.—*Faculty.*

7. The School should have a competent teaching staff. The Director must be a graduate in medicine and a pathologist of recognized ability. He shall take part in and be responsible for the actual conduct of the training course. He shall be in daily attendance for sufficient time to supervise properly the laboratory work and teaching.

8. In laboratory practice the enrolment shall not exceed one student to each member of the teaching staff. The staff should include not less than one salaried instructor who is a registered technician or eligible for registration in addition to the laboratory director.

III.—*Clinical Facilities.*

9. Each student should receive practice training, adequate in kind and amount under competent supervision, in a hospital laboratory. The hospital should be registered by and be otherwise acceptable to the Council on Medical Education and Hospitals of the American Medical Association and have a minimum of 2,000 yearly admissions. There should be a minimum of 15,000 tests and examinations carried out in the laboratory department annually.

10. Adequate space, light and modern equipment shall be provided in the laboratory department. A library containing up-to-date references, texts and scientific periodicals pertaining to clinical laboratory work and pathology should be maintained.

11. Satisfactory record systems shall be provided for all work carried on in the department. Monthly and annual classification of the work of the department should be prepared.

#### IV.—Curriculum.

12. A. Candidates for admission should be able to satisfy one of the following requirements :

1. Two years of college work, including chemistry, biology and physics from an accredited college or university.

2. Graduation from a school of nursing recognized by the state board of nurse examiners, and in addition college chemistry.

B. The course of training shall be not less than twelve months in duration and shall include the following divisions :

1. Biochemistry.

4. Parasitology.

2. Hematology.

5. Histologic technic.

3. Bacteriology.

6. Serology.

The instruction shall include :

1. Text assignments.

3. Demonstrations.

2. Lectures.

4. Quizzes.

5. Examinations—written, oral and practical.

#### V.—Ethics.

13. Exorbitant fees and commercial advertising shall be considered unethical.

14. Schools conducted primarily for the purpose of substituting students for paid technicians will not be considered for approval.

### ESSENTIALS OF AN ACCEPTABLE SCHOOL FOR PHYSICAL THERAPY TECHNICIANS.

#### I.—Organization.

1. A school for physical therapy technicians should be incorporated as or under a non-profit institution. Its board of trustees should be composed of public spirited men or women having no financial interest in the operations of the school. The trustees should serve for fairly long and overlapping terms. If the choice of trustees is vested in any other body than the board itself, that fact should be clearly stated. Officers and faculty of the school should be appointed by the board.

2. Affiliation with a college, university or medical school is highly desirable but is not an absolute requirement.

#### II.—Faculty.

3. The school should have a competent teaching staff, graded and organized by departments. Appointments should be based on thorough education and training and successful teaching experience. Nominations for faculty positions should be made in accordance with academic custom. The staff should include not less than one qualified salaried instructor and in each institution where practical training is carried on not less than one qualified physical therapist. The question of full-time and part-time appointments is not as important as the qualifications of the instructors, who should be specialists or exceptionally well trained and well qualified in the lines they are teaching.

### III.—*Plant.*

4. The school should own, or enjoy the use of, buildings sufficient in size to provide adequate lecture rooms, class laboratories and administration offices. Adequate equipment should include anatomic charts, manikins, models, stereopticons and other aids to effective teaching. It is suggested that dissecting materials should be provided to enable each student to dissect or have the benefit of demonstration of dissection of at least the lateral half of the human cadaver. Skeletons and disarticulated bones should be supplied. There should be a library receiving regularly all the scientific periodicals pertaining to physical therapy, current numbers of which should be easily accessible to the students.

### IV.—*Clinical Facilities.*

5. Provision should be made for each student to receive practice training adequate in kind and amount under competent supervision in physical therapy in a hospital or other institution acceptable to the Council on Medical Education and Hospitals of the American Medical Association.

### V.—*Resources.*

6. Experience has shown that a modern school of physical therapy cannot as a rule be maintained by the income from students' fees. No physical therapy school, therefore, should expect to secure approval which does not have a substantial income in addition to students' fees.

### VI.—*Administration.*

7. There should be careful and intelligent supervision of the entire school by an executive officer who, by training and experience, is fitted to interpret the prevailing standards in physical therapy education, and who is clothed with sufficient authority to carry them into effect.

8. There should be satisfactory records, showing conveniently and in detail the credentials, attendance, grades and accounts of the students, by means of which an exact knowledge can be obtained regarding each student's work. Except for good cause, such as for illness, no credit should be given for any course when the attendance has been less than 90 per cent. of the full time.

### VII.—*Requirements for Admission.*

9. Candidates for admission should be able to satisfy one of the following requirements :

(a) Two years or sixty semester hours of college, including courses in physics and biology.

(b) Graduation from an accredited school of nursing.

(c) Graduation from an accredited school of physical education.

Courses in general physics, chemistry and biology are highly recommended for all who seek to enter training in physical therapy.

10. The admission of students to the physical therapy school must be in the hands of a responsible committee or examiner, whose records shall always be open for inspection. Documentary evidence of the student's preliminary education should be obtained and kept on file. When the physical therapy school is an integral part of the university, this work usually devolves on the university examiner.

11. Advanced standing may be granted to students for work done in other acceptable physical therapy schools or hospital departments, provided the entrance requirements and other essentials herein set forth have been complied with. Official verification of the student's previous physical therapy work should be obtained by direct correspondence with the schools previously attended, and his preliminary qualifications should also be verified and recorded the same as for first-year students.

12. Complete physical examination of each student admitted should be conducted under the auspices of the school.

#### VIII.—*Publications.*

13. The school should issue, at least annually, a bulletin setting forth the character of the work which it offers. Such announcement should contain a list of the members of the faculty with their respective qualifications.

#### IX.—*Minimum Curriculum.*

Subjects.	Hours	
	Theory	Lab. & Practice training.
Anatomy (including applied anatomy, demonstration on cadaver and lecture) ..	210	
Clinical practice ..	..	400
Electrotherapy ..	30	45
Ethics and administration ..	5	..
Hydrotherapy ..	5	15
Massage ..	15	45
Pathology ..	30	..
Physiology ..	30	45
Principles of physical therapy as applied to :—		
Medicine ..	15	30
Neurology ..	15	15
Orthopedics ..	15	30
Surgery (including surgical observation) ..	15	30
Psychology ..	15	75
Therapeutic exercise ..	30	75
Electives ..	45	..
Total 1,200 hours ..	470	730

Suggested electives : asepsis, bandaging, first aid, history of physical therapy, hygiene, joint measurements, office routine, occupational therapy, records, social service.

All subjects should be taught by qualified teachers.

Length of course : Not less than nine months.

#### ESSENTIALS OF AN ACCEPTABLE SCHOOL OF OCCUPATIONAL THERAPY.

##### I.—*Organization.*

1. A school of occupational therapy should be incorporated under the laws regulating associations operated not for profit. The control should be vested in a board of trustees composed of public spirited men or women having no financial interest in the operation of the school. The trustees should serve for fairly long and overlapping terms. If the choice of trustees is vested in any other body than the board itself, this fact should be clearly stated. Officers and faculty of the school should be appointed by the board.

2. Affiliation with a college, university or medical school is highly desirable but is not an absolute requirement.

3. Schools of occupational therapy should not be operated by hospitals independently. It is understood, however, that hospitals are needed for practice training in the several branches of occupational therapy as required under clinical affiliations.

## II.—*Resources.*

Experience has shown that an adequate school of occupational therapy cannot be maintained solely by the income from students' fees. No occupational therapy school, therefore, should expect to secure approval which does not have a substantial additional income.

## III.—*Faculty.*

The school should have a competent teaching staff, graded and organized by departments. Appointments should be based on thorough education and training and successful teaching experience. The staff should include no less than one regular salaried instructor and one registered occupational therapist. The question of full-time and part-time appointments is not as important as the qualifications of the instructors, who should be specialists or exceptionally well trained in the lines they are teaching.

## IV.—*Plant.*

1. The school should own, or enjoy the use of, buildings sufficient in size to provide adequate lecture rooms, class laboratories and administration offices. Equipment should be adequate for efficient teaching in the various departments.

2. A library containing standard texts and leading periodicals in occupational therapy should be provided.

## V.—*Administration.*

1. *Supervision.*—There should be careful and intelligent supervision of the entire school by the dean, director or other executive officer who, by training and experience, is fitted to interpret the prevailing standards and who is clothed with sufficient authority to carry them into effect.

2. *Records.*—There should be a good system of records showing conveniently and in detail the credentials, attendance, grades and accounts of the students, by means of which an exact knowledge can be obtained regarding each student's work. Schools should require that students be in actual attendance within the first week of each annual session and thereafter. Except for good cause, no credit should be given for any course when attendance has been less than 80 per cent.

3. *Credentials.*—The admission of students to the occupational therapy school must be in the hands of a responsible committee or examiner, whose records shall always be open for inspection. Documentary evidence of the student's preliminary education should be obtained and kept on file. When the occupational therapy school is an integral part of the university, this work usually devolves on the examiner or registrar.

4. *Advanced Standing.*—At the discretion of the administration, advanced standing may be granted for work (or experience) required in the occupational therapy curriculum which has been done in other accredited institutions. Official verification of previous work (or experience) should be obtained by direct correspondence. Preliminary qualifications should also be verified and recorded.



5. *Number of students.*—The number of students admitted to the training course should not be excessive. In practical work of a laboratory nature the number of students that can be adequately supervised by a single instructor is, in general experience, about fifteen : in lectures the number may be much larger. A close personal contact between students and members of the teaching staff is essential.

6. *Discipline.*—All training schools reserve the right to drop a student at any time for any cause which the school authorities deem sufficient.

7. *Publications.*—The school should issue, at least biennially, a bulletin setting forth the character of the work which it offers. Such an announcement should contain a list of the members of the faculty with their respective qualifications.

#### VI.—*Clinical Affiliations.*

1. No student should be eligible for entrance into clinical training until she has satisfactorily completed at least one academic year, equal to thirty semester credits, fifteen of which should be in biological science, social science, theory of occupational therapy and clinical subjects and fifteen in therapeutic occupations.

2. Hospitals or institutions affiliating for clinical training should be carefully judged by the board of directors of the school concerned and be acceptable to the Council on Medical Education and Hospitals and should not be considered eligible for training of students unless the director of the occupational therapy department is a competent occupational therapist qualified to handle students.

3. The occupational therapy director of each training department should be considered a member of a special committee on the training school staff and at all times be in close contact with the director of the school.

4. A well defined programme of lectures, clinics and staff meetings should be offered by the hospital to each group of students.

5. Written records, case studies and examinations should be required of each student. Students should obtain satisfactory rating in clinical training before a diploma is granted.

6. Uniform written records specially covering the student's personal adjustment as well as general ability should be kept by the occupational therapy director of each department, regular copy of which should be sent to the school at frequent intervals and all reports filed in the individual student's record at the school.

#### VII.—*Pre-requisites for Admission.*

1. *Age.*—The admission of candidates should be governed by the fact that it is required that each student be not less than 21 years of age at graduation.

2. *Education.*—All candidates must furnish proof of having completed a high school education or its equivalent. Equivalent of high school should be adjudged and recorded by the admissions committee of the school. In addition, all candidates except those for the degree course, must have had at least one year and preferably two years of further accredited education or successful professional training or experience.

Candidates for admission to training course in a college or university which is combined with work leading to a bachelor's degree should be required to comply with the regular entrance requirements of the institution concerned.

3. *Character*.—All candidates should be required to present evidence of good character and general fitness, the evidence of which should be investigated and duly weighed by the school concerned.

4. *Health*.—All students should be given a medical examination under the supervision of the school as soon as practicable after admission, and this examination should be repeated annually. The first examination, at least, should include a tuberculin test followed by a roentgen examination of the chest when indicated.

#### VIII.—Curriculum.

1. *Length of course*.—The minimum length of the course should be twenty-five calendar months (100 weeks) of full-time training. The course should include not less than sixteen months (sixty-four weeks) of theoretical and technical instruction and not less than nine months (thirty-six weeks) of hospital practice-training under competent supervision : all as set forth in detail in succeeding sections.

2. *Distribution of Time*.—The two years devoted to theoretical and technical training should include not less than sixty semester hours, of which not less than thirty semester hours should consist of didactic instruction and not less than twenty-five hours of technical instruction in therapeutic occupations.

(a) *Theoretical*.—The hours devoted to theoretical training should be still further subdivided as follows :—

	Semester hours.
(1) Biologic Sciences to include :	
Anatomy	} .. .. . 15
Kinesiology	
Neurology	
Physiology	
Psychiatry	
Psychology	
(2) Social Sciences to include :	
Sociology	} .. .. .
Delinquency and Crime	
Social and Educational Agencies	
(3) Theory of Occupational Therapy to include :	
Interpretative courses covering the principles and practice of occupational therapy in relation to orthopaedics, pediatrics, tuberculosis, psychiatry, general medicine, surgery and other special fields	.. .. .
(4) Clinical Subjects to include :	
Blindness and Deafness	.. .. .
Cardiac Diseases	.. .. .
Communicable Diseases (including bacteriology if this subject is not given elsewhere).	} .. .. .
General Medical and Surgical Conditions	
Orthopaedics	
Tuberculosis	
(5) Electives	.. .. . 3
Total	30

(b) *Technical*.—Because of the increasing demands of the medical professions for qualified therapists trained in special fields applicable to the education and training of disabled persons as well as to the treatment of the sick, there must be a certain amount of flexibility in technical requirements.

Concentration may be in the field of *Therapeutic Arts and Crafts*, in some branch of *Educational Therapy*, or in *Recreational Therapy*.

A minimum of thirty semester hours should be devoted to technical training. The major portion may be allotted to concentration in one field and, in this case, survey courses should be given in the other fields.

(1) The Field of Therapeutic Arts and Crafts to include:

Design.  
Leather.  
Metal.  
Plastic Arts.  
Textiles.  
Wood.

(2) The Field of Educational Therapy to include :

Adult Education.  
Fine and Applied Arts.  
Home Economics.  
Hospital Library Management.  
Primary and Secondary Education.

(3) The Field of Recreational Therapy to include :

Dramatics.  
Gardening.  
Music.  
Physical Education.  
Social Recreation.

Advanced standing may be given to students already qualified in one or more branches of the three fields. Such persons may then be given survey courses in the other fields of concentration, and practice in the application of their speciality to the treatment of disabled persons.

(c) *Clinical Affiliations.*—The time devoted to hospital practice-training shall be not less than nine months spent in the following types of hospitals:—

Mental hospital .. .. .	.. Not less than two months.
Tuberculosis sanatoriums or services .. .. .	.. Not less than one month.
General hospitals .. .. .	.. Not less than one month.
Children's hospitals or services .. .. .	.. Not less than one month.
Orthopaedic hospitals or services .. .. .	.. Not less than one month.

The remaining three months optional.

The Council acknowledges the splendid cooperation extended by the various schools included in the study and also the help of the officers and Educational Committee of the American Occupational Therapy Association. The Council will continue actively in the promulgation of high standards for schools of occupational therapy. Periodic re-examination of the approved schools will be made and revisions of the list will be published as indicated.

## APPENDIX 46.

## COURSE OF TRAINING RECOMMENDED FOR RESEARCH WORKERS.

*1st year* (intern year).—Act as demonstrator and assist in class laboratory preparations ; take such supplementary courses in pure or applied science as individuals may require.

*2nd year.* Junior assistant.—Assist in preparing class demonstrations ; assist in research ; participate, in rotation, in departmental routine ; build up personal reference files and notes for teaching, through historical reading ; prepare reviews for seminars.

*3rd year.* Assistant.—Supervise demonstrators ; assist in demonstrations ; give stated lectures ; assist in class examinations ; participate, in rotation, in departmental routines ; assist in research in association with others ; undertake independent research ; continue historical reading and the building up of reference files and notes ; assume responsibility for routine reporting on current literature in one field.

*4th year.* Senior Assistant.—Supervise junior assistants ; give stated demonstrations and lectures ; assist in professional or final examinations ; complete rotation in departmental routines and in taking charge of seminar programmes ; carry out independent research ; complete preparations of personal reference files and notes for teaching ; prepare lists of equipment, apparatus, etc., with addresses of suppliers, prices, etc. ; prepare a budget.

During the period of training, provision should be made for trainees to acquire a working knowledge of biomathematics, languages (e.g., French, German and basic Latin) and library methods. Opportunities should be developed to ensure contacts with workers in other fields of medicine and other faculties ; to promote reading of current events and non-medical literature ; to ensure acquaintance with industrial, agricultural and Government processes and organization so as to develop a general understanding of contemporary life and of the place and potentialities of medicine ; to develop team work, discipline and leadership ; service in a medical O. T. C., participation in athletics and in various societies should be required or encouraged. In practice, it may be found expedient and economical to arrange for instruction in subjects of more or less common interest for groups of trainees from different fields of study.

*Special Advanced Training.*—Arrangements should be made to enable outstanding trainees to go abroad to work with an acknowledged master, in their respective fields of study, for at least one year and to visit workers in other countries and in other universities on completion of their period of study. This should be regarded as part of the training necessary to develop the very best men. It also provides a basis for future international cooperation and raises the standard of endeavour to an international, rather than narrow national, level.

*The Fields of Training.*—In view of the advances made in both the pure and applied aspects of medicine, and opportunities for advancement resulting therefrom, as well as new problems which they have created, it is suggested in connection with the teacher training programme that the following teaching fields be covered :—

A trainee would be expected to cover the subjects under *one* main field (indicated by Roman numbers), but in the case where there are positions available for specialization within a field (e.g., lectureship or professorship in bacteriology or parasitology in the field of microbiology) the trainee would spend further time on the speciality.

**I.—Anatomy :—**

- (a) Anatomy—
  - (i) Histology,
  - (ii) Descriptive Anatomy,
  - (iii) Neural Anatomy,
  - (iv) Racial Anatomy,
  - (v) Anthropology.
- (b) Developmental Morphology—
  - (i) Embryology and genetics,
  - (ii) Postnatal growth, maintenance and repair,
  - (iii) Decline and degeneration.

**II.—Physiology :—**

- (i) Systemic Physiology,
- (ii) Human (or organism) Physiology,
- (iii) Biostatistics.

**III.—Biochemistry :—**

- (a) Biochemistry proper—
  - (i) Physical Chemistry,
  - (ii) Organic Chemistry,
  - (iii) Physiological Chemistry.
- (b) Normal Nutrition.

**IV.—Pharmacology :—**

- (i) Experimental or normal Pharmacology,
- (ii) Therapeutics or Pathological Pharmacology,
- (iii) Pharmaceutical Chemistry,
- (iv) Chemotherapy.

**V.—Pathology :—**

- (a) Pathology proper—
  - (i) Morbid Anatomy and Histology,
  - (ii) Experimental Pathology,
  - (iii) Clinical Pathology.
- (b) Forensic Medicine.
- (c) Microbiology—
  - (i) Parasitology and Medical Zoology.
  - (ii) Bacteriology,
  - (iii) Immunology and Serology,
  - (iv) Mycology.

**VI.—Clinical Medicine :—**

- (a) General Medicine—
  - (i) Communicable diseases.—
    - (a) Malariaology,
    - (b) Other Vector spread diseases,
    - (c) Non-vector spread diseases—
      - tuberculosis,
      - venereal diseases etc.
  - (ii) Metabolic diseases,
  - (iii) Cardio-vascular diseases,
  - (iv) Respiratory diseases,
  - (v) Diseases of the digestive system,
  - (vi) Diseases of haematopoietic (blood forming) system,
  - (vii) Diseases of the ductless glands (endocrinology),
  - (viii) Dermatology (diseases of skin).

**VII.—Neurology and Neuro-Surgery****VIII.—Psychiatry.****IX.—Surgery :—**

- (i) General Surgery (including abdominal surgery).
- (ii) Orthopaedic Surgery,
- (iii) Chest Surgery,
- (iv) Surgery of ear, nose and throat,
- (v) Ophthalmology,
- (vi) Reconstructive (Plastic) Surgery,
- (vii) Genito-Urinary Surgery.

**X.—Anaesthetics.****XI.—Diseases and conditions peculiar to women.**

- (i) Obstetrics,
- (ii) Gynaecology.

**XII.—Paediatrics.****XIII.—Radiology :—**

- (i) Radiation and Physiotherapy,
- (ii) X-Rays,
- (iii) Radium.

**XIV.—Prophylactic Medicine :—**

- (a) Epidemiology and Vital Statistics,
- (b) Social Pathology,
- (c) Hygiene—
  - (i) Health Education,
  - (ii) Control of Diseases—
    - a. communicable,
    - b. nutritional,
    - c. mental.
- (d) Public Health Administration,
- (e) Maternity and Child Welfare,
- (f) School Health,
- (g) Occupational Health—
  - (i) Industrial,
  - (ii) Agricultural,
- (h) Public Health Engineering.

**XV.—Social Medicine :—**

- (i) Applied Epidemiology,
- (ii) Social Pathology,
- (iii) Social Surveys,
- (iv) Social Experiment,
- (v) Study of Health *per se*.

**XVI.—History of Medicine.****XVII.—Collegiate School of Nursing :—**

- (i) Vocational Nursing,
- (ii) Public Health Nursing,
- (iii) Nursing Administration,
- (iv) Nursing Education,
- (v) Nursing Research & Experiment.

**XVIII.—Dental Medicine.**

Trainees must be provided with an adequate stipend throughout their course of training, all teachers must be full-time employees.

## APPENDIX 47.

THE NEED FOR AN INSTITUTE OF THE HISTORY OF MEDICINE  
IN INDIA.*Henry E. Sigerist.*

It is no longer necessary to stress the value of studies and of academic instruction in the history of medicine. Since 1905, the year when the Leipzig Institute was founded by Karl Sudhoff, one country after another has developed similar institutions. They became cultural centres from which the field of historical studies was broadened considerably and medicine was greatly enriched.

A survey undertaken in the United States in 1937 revealed that courses in the subject were offered in 54 of the 77 medical schools then existing<sup>1</sup>. It must be admitted, however, that in the majority of these schools the standard of instruction in medical history was far below their general academic standard, and that only very few of them engaged in serious research. Nevertheless, the mere fact that 70 per cent. of all medical schools thought it advisable to include medical history in the curriculum shows that the significance and possibilities of the subject have been recognized.

## I.

In a country such as India a centre of studies in the history of medicine is more necessary than anywhere else, because in India ancient and mediaeval medicine are still alive and are practised on a large scale. It is no exaggeration to say that the overwhelming majority of the people of India receive medical care only from indigenous practitioners. They either follow the principles of the *Ayurveda*—the Science of Longevity—as it developed in the Atreya school of Brahmin doctors over two thousand years ago or they are adepts of the *Unani*, or Greek school of medicine which actually is Arabo-Persian medicine—to mention only the two major systems.

The fact that indigenous medicine plays such a very important part in the life of the Indian people is frequently minimized or even ignored. And yet it represents a very tangible reality that must be faced openly whenever plans are elaborated for improving the health conditions of the country particularly since its popularity is growing rather than diminishing. New indigenous schools are being founded. They are subsidized by the government in several provinces. The Osmania University of Hyderabad has a Medical College which is a Unani Medical College. The Medical Practitioner's Act of Bombay of 1938 admits graduates of indigenous schools to the Medical Register.

At first sight it seems strange that these ancient indigenous systems are able to compete with modern scientific medicine. It was not strange in the 17th and 18th centuries when the two worlds first entered into contact. At that time European medicine was developing new theoretical foundations but in practice, in the treatment of disease it was hardly more effective than Greek, or Hindu, or Arabic medicine. But today? Nobody can deny that scientific medicine during the last hundred years has made tremendous strides. Bacteriology and immunology have permitted us to combat communicable diseases most effectively and to eradicate many of them. Modern surgery is able to save thousands of human lives that would have been lost

<sup>1</sup> *Bulletin of the History of Medicine*, 1939, 7 : 627-662.

only fifty years ago. Pediatrics, more than any other branch of medicine, is responsible for the decrease of death rates and for the greater life expectancy. The treatment of internal diseases, for a long time the step-child of medicine, has greatly progressed also. The discovery of hormones and vitamins made it possible to attack certain diseases at the root, and in the last few years the sulpha-drugs and penicillin have proved to be formidable weapons in the treatment of many formerly deadly diseases. How then was it possible for indigenous medical systems to survive ?

The reasons are not difficult to find. India with its 19 University Medical Colleges and 19 Medical Schools has produced physicians trained in scientific medicine, but not enough of them. It is impossible for 55,000 doctors to give medical care to a population of nearly 400 million, particularly since economic necessity forces the majority of doctors to practise in the cities, while 90 per cent. of the people live in rural districts. The sick villager therefore, has hardly any choice ; if he wants help and advice he must have recourse to an indigenous practitioner.

There are Rural Dispensaries operated by the provincial or local governments, staffed with scientific doctors. These dispensaries, however, are as a rule very poorly equipped ; the doctor sees hundreds of patients every day, so that he has not the time to examine the sick and to treat him individually. He can at best practise a primitive type of first-aid and bottle medicine which are hardly apt to demonstrate the superiority of Western medical science. The salary of the dispensary doctor, moreover, is so miserably small, that he is forced to make a living through private practice. But the average villager is too poor to pay for his services and to purchase his imported chemical drugs. And so the sick call on the indigenous practitioner who himself is a villager, whose drugs consist of native herbs that are cheap, and whose theoretical views conform with the religious views of the patient.

The indigenous systems of medicine, both Ayurveda and Unani, are strongly philosophical in outlook, although their original character has degenerated in many ways. The theory of the three elements in one, of the four humors in the other, are attempts to visualize the organism as a microcosm and to place it into relationship with the macrocosm of the universe. Hindu philosophy as it crystallized in the system of the Tantras, looks at the human body and at the universe as a manifestation of divine substance and energy, a concept the elements of which can be traced back to Vedic traditions. The three elements wind, bile, and phlegm are symbols of the aerial, fiery, and liquid forces of life-energy. Throughout its history Ayurvedic medicine was an attempt to interpret the phenomena of life and death, of health and disease, philosophically.

Unani medicine, on the other hand, through the Persian and Arabic tradition goes back to Galenic, Hippocratic and Pythagorean views and having passed through the filter of Avicenna, it acquired many elements of Aristotelian philosophy.

Indian culture is deeply imbued with philosophy, and this is why not only illiterate villagers but highly educated men sometimes prefer the indigenous systems to scientific medicine and rise to their defence. They claim that the medicine that came from the West is too mechanical, that it is soulless, that it has no philosophy, that it is foreign to Indian thought, while the indigenous systems are deeply rooted in the religious and philosophical traditions of the country, and represent one aspect of the general attitude towards nature and man.



There is another most powerful force that is backing the indigenous systems of medicine, Indian nationalism. The country is in a period of transition. After centuries of stagnation the people of India are awakening to new life and look into the future. A regular Renaissance is taking place. A nation which had developed a great civilization at a time when we in the West were still savages, which for certain historical reasons too complex to be discussed here declined, is now reasserting itself.

At such a historical moment the people look back with pride to their cultural heritage. It is the common ground on which they stand. The classical literature is published in new editions. The cinema instead of filming gangster stories revives Sakuntala. Young girls dye their palms and soles with henna and re-enact old dances. The country's archaeological remains are carefully preserved, tactfully restored, and visited by thousands. Hindus and Moslems, Sikhs and Parsis alike admire the paintings of Ajanta, the sculptures of Elefanta, the temples of Madura and the palaces of the Mogul emperors. They justly feel, beyond communal lines, that they are theirs.

And when it comes to medicine, they remember their history also. Just as we look to Hippocrates as the father of medicine, they look to their own classics to Caraka, Susruta, Vagbhata who collected and preserved the medical lore of their time; or to the classics of Arabic and Persian medicine who in the early Middle Ages had assimilated, enriched and systematized the Greek tradition and were far ahead of their colleagues in the West. Indians remember with pride that in the 3rd century B. C. Asoka, the great Buddhist Maurya king had provided medical services for rich and poor, for men and animals, throughout his empire; that he had hospitals built in town and country, for men and animals, at a time when there was not a single hospital in the Western world.

This great medical tradition is not dead. It is alive like the Vedas, the Upanisads or the immortal Meghaduta, like the Qoran, the Bustan and the Gulistan. It is no wonder that India reasserting itself is backing up its own systems of medicine.

## II.

So far, so good—but medicine is neither poetry nor philosophy. It is a craft, a techne as the Greeks called it, with an eminently practical purpose. Its goal in every country is the same, namely to promote the people's health, to prevent disease, to restore health when it has broken down, and whenever necessary, to rehabilitate the former patient so that he may remain a useful member of society.

The question naturally arises: have the indigenous systems succeeded in establishing a high standard of health in India? The question can be answered scientifically because health conditions can be measured and can be expressed in figures. When we consult these figures and find that in 1937 the general death rate was 22.4, the infantile mortality rate 162, and the average life expectancy only 27 years, we must conclude that health conditions are very bad in India today, infinitely worse than in countries that have universally accepted scientific medicine.

It is well known that health conditions are determined not only by the status of medicine but also by the general standard of living—which in India is extremely low. When people have not enough to eat, constantly suffer from malnutrition and live in a poor sanitary environment they are always threatened by disease and have little resistance to offer. Scientific

medicine, however, has forged weapons with which it is possible to eradicate diseases even under poor living conditions. The numerous diseases carried by water and food can be brought under control by general public health measures. The various methods of immunization permit the prevention of diseases which today still take a heavy toll of life in India, and the new methods of treatment can save thousands of human lives that would be lost otherwise. The incidence of malaria, India's great curse, could be reduced considerably if the doctors had enough auxiliary personnel available that they could steer and guide.

If Indians take a historical attitude toward their indigenous systems of medicine, they will be justly proud in realizing what a great advance these systems represented *at their time*, in antiquity and the Middle Ages. They brought many effective drugs to the people, many valuable dietetic and even surgical treatments. But Indians will also realize that conditions have greatly changed. The new science that developed from the 16th century on created a new foundation of medicine, a new anatomy, physiology and pathology on the basis of which new systems of public health and of clinical medicine could be developed with infinitely more effective methods of prevention and cure. The theory of medicine, the views we have of the causes and mechanisms of disease are not a luxury but determine our actions. The concepts of wind, bile and phlegm or of blood, phlegm, yellow bile and black bile represented useful working hypotheses at their time, but the new science has demonstrated that the actions attributed to them are the result of speculation and do not correspond to a reality, while it is possible to explain the phenomena of health and disease with concepts of biology, physics and chemistry in an infinitely more satisfactory way, one that permits testing in experiments and has led to brilliant practical results.

Indians, therefore, who have the welfare of their people at heart, who want them to live without being constantly fettered by the bonds of disease, cannot but accept scientific medicine and work to promote it and to see it applied on a nation-wide scale so that it may reach every single village. It, of course, is not easy to apply modern science to one field of human endeavour while other basic functions of social life such as agriculture and industry remain mediaeval and women are kept in purdah. And this raises the question: is it at all desirable for a nation to accept science and technology or would it be better for the people to remain static, to live poor and contented, bearing sufferings with resignation, leading a contemplative life and hoping for a better lot in the hereafter? The question seems justified in view of the evil use that has been made of science in recent years. It is futile, however, because there is no choice. No nation can expect to survive in the present world as a nation unless it accepts science with all its implications. And science in itself is neither good nor evil. It is an instrument in the hands of man, and it is he who is good or evil.

India, after centuries of stagnation, is awake today and has expressed its determination to free the people from age-old bonds. Thousands of young men and women are flocking to the universities, hundreds of them travel abroad for post-graduate study. Already India has produced physicists, chemists and biologists of world renown. Industries are being developed. The great rivers dammed by engineering skill, will produce water for irrigation and power for new industries that will absorb the rural surplus population. India possesses the manpower and natural resources needed to make it a prosperous country in which the people will be free to produce new cultural values as they did in the past. This may seem Utopian in

view of the many traditional barriers of caste and religious taboos that tend to divide the people, but the example of other countries has shown that however rigid the traditional superstructure may appear, it breaks down very rapidly where there is a strong popular movement that attacks the basic elements of economic and social life.

In the same way scientific medicine must be developed. Promising beginnings have already been made and plans are elaborated for the future. The line to be taken is clear. The country needs more and better trained personnel, researchers, teachers, doctors and legions of auxiliary personnel. It needs more and better equipment. And it needs first of all a system of health services that will make full use of the personnel and equipment available and will bring it into the reach of everybody.

Scientifically trained doctors will gradually replace the indigenous practitioners. The argument that indigenous medicine is cheaper will no longer hold, because medicine will not be a service that is sold to the people in the open market, but a public service to which they are entitled, one that is financed on public funds. Similarly the argument that indigenous drugs must be preserved because they are within the financial means of the villager will vanish, because drugs will not be sold but distributed to those who need them, and the development of a state-owned and operated pharmaceutical industry will considerably reduce the cost of production of modern scientific drugs.

Such a development will obviously take a long time, and meanwhile the country will continue to have tens of thousands of indigenous practitioners, registered and non-registered, trained in schools and trained through apprenticeship. It would be worthwhile to study whether these practitioners could not be used during the period of transition as auxiliary personnel. In some of their schools students are given a sprinkling of scientific medicine, and while it is obviously impossible to combine modern medical science with ancient and mediaeval theories, it should be possible to train these students for a few specific functions such as the combating of malaria, vaccination and other immunizations, the supervision of wells and latrines and other public health measures.

### III.

It seems to me that in such a period of transition an Institute of the History of Medicine could play a very important part.

The Government of India plans to establish a National Medical College, a model medical college that would become a national centre of medical research and a training ground for highly qualified physicians, specialists, and academic teachers. This undoubtedly is an excellent plan that will give a tremendous stimulus to the development of medicine in India and will raise the standard of medical education and consequently of practice.

The opportunity of creating a new school is one that occurs very rarely and presents great opportunities that should not be missed. It is extremely difficult to modernize an old school that is burdened with the weight of a great tradition. A business enterprise that does not keep abreast of the time soon collapses, but out-moded universities may carry on indefinitely, much to the detriment of the country.

Whoever founds a new medical college today must be fully aware of the changes that have occurred in medicine and society and of the social and economic structure into which the products of the college, the physicians,

will have to fit. It would be a mistake therefore merely to copy a British or American pattern. When the Johns Hopkins School of Medicine was opened in Baltimore in 1893 it was neither a replica of a British, French or German school. It had taken over elements of the various European systems but had blended them to form a new pattern that was in many ways better than the existing ones, and this is one reason why the school became so influential.

India is neither Britain or America. It is a tropical country, and its social and economic structure is totally different. And while the medical science in which students are instructed is basically the same all over the world, the application of this science varies a great deal. In small countries such as Switzerland or Holland the problem of rural medicine hardly exists because cities are never far away and hospitals and specialists can be reached easily. In tomorrow's India the great majority of all doctors must be scientifically well trained physicians prepared to practise in rural districts among poor people under an organized system of medical services. But they will have to be more than mere therapists; they will have to be teachers and social workers, leaders and friends of the people, leading them to a healthier and happier life. An Institute of Social Medicine should, therefore, be considered.

The new college, I am well aware, intends to be primarily a centre of research and a training ground for specialists and teachers. It is just for that reason that it should emphasize the social aspects of medicine. Research is needed not only in the science but also in the sociology of medicine—and in India perhaps more than anywhere else. It is a fallacy to believe that the application of scientific results takes care of itself. It does not, as we have found in every country, and the most brilliant discoveries are wasted unless they can be applied on a mass-scale. The teachers who will come from this college, on the other hand, no matter whether they are physiologists or surgeons should all carry that social outlook into whatever colleges they may be called. The National College will set a new pattern of medical education in India, one that undoubtedly will be followed by the other schools.

Similarly, since India is confronted with the problem of indigenous medical systems and will be so far a long time, an Institute of the History of Medicine could greatly help to clarify the situation, and I should like to outline briefly what I would consider the major tasks of such an Institute.

The history of medicine is both history and medicine. It is a historical discipline like the history of art or the history of philosophy. It helps to give us a more complete picture of the history of civilization, because it is obviously not unimportant to know what diseases affected the people in the past, what they did not protect and restore their health and what thoughts guided their action.

But the history of medicine is also medicine. By analyzing developments and trends it permits us to understand a situation more clearly and to act more intelligently. We all know that success or failure of our medical work depend not only on the scientific knowledge we possess but also on a great variety of other non-medical factors, on economic, social, religious, philosophical, political factors that are the result of historical developments. Unless we are aware of them and understand them many of our efforts will be wasted.

An Institute of the History of Medicine in India will devote its researches primarily to the history of Indian medicine and of medicine in India, from the Vedic period to our days. It will investigate the medical heritage of the country dispassionately and critically, not in order to prove a point. It will endeavour to reconstruct and envisage the medical past of India from the perspective of history, in relation to and as part of the general civilization of the various periods.

In order to be able to write history the historian must first proceed analytically investigating and interpreting historical sources which in many cases have to be made available first. The chief medico-historical sources are texts and the Indian medical literature still requires a great deal of purely philological work. Many texts still have to be edited critically and many have to be translated. One of the most important Sanskrit medical classics, Vagbhata's *Astangahridayasamhita* was translated only a few years ago. I am convinced that there are still many medical texts buried in manuscripts that have not yet been touched. Our Johns Hopkins Institute possesses a collection of Sinhalese medical manuscripts written on palm leaves that have not been edited and therefore have obviously never been translated or evaluated.

The study of texts will not be limited to books written in Sanskrit, Prakrit or Pali but will be extended to Arabic and Persian books and to those written in vernacular languages. Sources of medical history, however, are not only medical books. Other books, religious, theological, philosophical, and histories, biographies, memoirs, etc., may contain valuable information concerning health and medical conditions at a given time. It will, therefore, be necessary to canvass the entire Indian literature for medical data. Dr. D. V. S. Reddy of Andhra Medical College in Vizagapatnam has shown how the Rock Edicts of Asoka are a rich source for our knowledge of medical conditions at the height of the Maurya empire. There can be no doubt that such books as the *Ain-i-Akbari* and the autobiographies of the Mogul emperors contain a great deal that is of medical interest.

Books, however, are not the only sources of medical history. The antiquities, sculptures, paintings, buildings, instruments and other objects of archaeological research may be able to shed light on health and medical conditions and must therefore be consulted. The elaborate bathing facilities in Mogul palaces were a luxury, to be sure, but also had hygienic consequences and it mattered a great deal what kind of drinking water people had available and how they disposed of their sewage.

In a country like India where traditions have persisted tenaciously through the centuries and where the Middle Ages are still alive in many ways, the medical folklore is another rich historical source that must be consulted. This, however, must be done cautiously and critically because folklore always is a big hodgepodge in which ancient, mediaeval and modern views are inextricably mixed.

The Institute will not limit its studies to India because India was never isolated from the rest of the world. The Aryan conquerors came from the northwest and brought views and concepts that belonged to the common stock of all Indo-European races. Babylonian civilization radiated far over Asia, and India had intercourse with China at an early date. The caravan was a factor that greatly contributed to the spreading of stories, ideas, knowledge and skills all over the continent. Invading

armies invariably had surgeons who brought knowledge to foreign lands and learned from them. The influence of Alexander the Great's campaign is reflected not only in the sculptures of Gandhara but in many ways, and Indian drugs were sold in Alexandria. The close relations of India with the Islamic world need not be emphasized here and from the 16th century on India had inter-relationships with Europe. The Institute therefore will study the history of Indian medicine as part of the universal history of medicine.

The critical evaluation of historical sources permits us to reconstruct the past. In the case of medicine it permits us to ascertain—if sufficient sources are available—what diseases afflicted the people in various periods, how their lives were affected by them, what they did to maintain and restore their health and what thoughts were guiding their actions.

The history of medicine differs basically from most other historical disciplines that examine happenings and phenomena which occurred once, because it is the history of a craft, of techniques and skills. We therefore want to know not only what people did in the past to maintain and restore their health, but also whether they did a good job or not, whether their treatments were effective or not. This is why historians of medicine must not only be historians but physicians as well. Ancient treatments can be repeated, the efficacy of drugs can be tested in experiments.

The Institute will therefore investigate the indigenous medical systems not only for their ideological content, not only as aspects of India's ancient and mediaeval civilizations and as end products of a long development: it will also endeavour to evaluate their practical achievements. This obviously does not mean that the historical institute should have a laboratory for the testing of drugs. Certainly not, but the historian of medicine on the basis of his studies of the classical literature and of field work would be able to point out which treatments and drugs should be tested by the pharmacologists and clinicians of the College. This would permit us to preserve and to incorporate into our scientific system of medicine whatever is found to be of value in the indigenous systems. And it would also permit the objective refutation of claims that are not justified.

Thus the Institute, besides being a humanistic centre, would also have some practical functions that could be extended in many directions. A physician can cure an individual case of syphilis without any knowledge of history, but whoever plans a campaign against venereal diseases must take a great many non-medical factors into account and will be confronted with social, economic and religious conditions that are the result of historical developments of which he should be aware. Health education is wasted unless it is somehow combined with education in citizenship which is impossible without history. I should think that at the present moment when India is planning to develop its medical services and to bring health to the villages, the cooperation of a physician who can think in terms of history, should be extremely valuable. And the Institute by collaborating with the departments of social medicine, hygiene and public health should be able to make important contributions.

#### IV.

There is another field in which the Institute of the History of Medicine as a department of a National Medical College could render great services, the field of education. It could greatly enrich the curriculum.

Whenever a country adopts scientific medicine it usually does it with great enthusiasm and is inclined to throw everything overboard that is not science. The result is that physicians are produced who are highly trained technicians without any education, high grade specialists who see only one small section of medicine and have lost sight of the goal. Medicine is not a natural but a social science. Its target is to keep men adjusted to their social and physical environment as useful members of society, and to readjust them when prevention has broken down. Methods of the natural sciences have to be applied to this end, but the goal is social and the physician should always keep this broad purpose in view.

If I am correctly informed, the general education of the average medical student in India—as in many other countries—is rather scanty. From the moment he leaves the secondary school his training is along scientific lines. He has the added handicap that he is instructed in a foreign language—by necessity in view of the diversity of Indian languages. He may be familiar with English literature from Chaucer to Kipling and hardly know his own classics. I met Indians who admitted that they would find it difficult to deliver a lecture in their own Urdu or Bengali or whatever their mother tongue may have been. This peculiar situation obviously tends to divorce the small educated upper class from the mass of the people. But if there is one profession that must be close to the people it certainly is the medical profession, because the doctor must not only be a therapist but a teacher and friend of the people he serves.

Instruction in medical history, if properly conducted, could greatly contribute to the training of an educated physician. It would teach the student history, the history of his own country but also the history of the world with a bias on medicine that would bring the subject much closer to him. It would teach him to look at modern medicine from the perspective of history and to see it in all its economic, social, religious and philosophic implications, as the result of a long development, as a dynamic process. He would soon find that scientific medicine has a philosophy also. We too look at the human body as a microcosm in the midst of the microcosm. The same elements that constitute the organism are found in the outside world, and the same physico-chemical forces are acting in both. The physician thus trained would have a much clearer idea of the task of medicine and of the part he is called upon to play in society.

Such instruction would also help to develop the spirit that must animate the physician in his work. He must realize that medicine is not a means of becoming rich but a service to the people. The same splendid spirit that drove an elite of medical students to volunteer their services during the recent Bengal famine must permeate the entire medical corps at all times. Only in such a way will it be possible to carry out an ambitious programme and to bring health to the villages.

The Johns Hopkins School of Medicine is often looked upon as the example of a school that succeeded in creating a new pattern of medical education in its country by raising entrance requirements and emphasizing scientific instruction in the laboratory and at the bedside of patients. This is correct but one should also remember that the men who made the School famous were not only great scientists but humanists also. Osler, Welch, Kelly Halsted were keenly interested in the history of medicine and never missed an opportunity to impart historical knowledge to their students. In 1890, one year after the opening of the Hospital, three years before the School opened

its doors, they founded the Johns Hopkins Medical History Club which is today in the fifty-fifth year of its activities. Osler's historical and philosophical essays will remain a source of inspiration long after his scientific papers and his textbook are forgotten. When the School was opened in 1893 the new curriculum included a course in the history of medicine that was given by John Billings, one of the great pioneers of American medicine, who drew up the plans for the Hopkins Hospital and was largely responsible for the new curriculum. And at the end of his career William Welch, in 1929, created the Johns Hopkins Institute of the History of Medicine, the first of its kind in the United States. I think these facts are highly significant and provide food for reflection.

## V.

After all that has been said, it is easily apparent what the structure of such an institute must be. It will require personnel and equipment. Since it will not be possible to find a physician well trained in methods of historical research who masters equally well Sanskrit, Greek, Arabic and Persian, the Institute will need a staff of at least three scholars who will work as a cooperative group. One of them, a student of Sanskrit and other Indian languages will specialize on Hindu medicine. The second will devote his researches primarily to the Moslem phase of Indian medicine and will therefore be an expert in Arabic and Persian medicine, while the third will be a general medical historian and will study the history of Western medicine in its relations with the East and the rise of scientific medicine.

The staff will require tools for research, that is, collections and among them primarily a collection of books. The library of the Institute will include the basic medico-historical literature—books and journals—medical texts in the best editions and translations available, and as many reference books as possible. It should also include a number of non-medical books, such as basic books on political, social and economic history, the history of philosophy, religion and other disciplines, books that are constantly needed for general orientation.

The Institute will in addition collect other documents pertaining to the medical history of India, manuscripts, photographs, portraits, objects such as instruments, etc. and it may consider the creation of a museum of indigenous drugs.

Whoever organizes such an Institute today must endeavour to relieve the research and teaching staff of administrative burdens as much as possible. University administration is in many countries the most wasteful and cumbersome of all administrations in that it uses highly trained scientists and scholars for the solution of petty administrative problems that could be handled by general office workers just as well if not better, and this greatly reduces the efficiency of a faculty. The National Medical College will obviously have a strong Medical Library and it would be advisable to build the institute of the History of Medicine in connection with or as an annex to the Library, so that the technical administration of the Institute could be handled by special employees of the Library. This would permit the staff of the Institute to devote all their efforts to research and the teaching of students.

This is not the place to discuss matters of budget, but there can be no doubt that the cost of erecting and operating such an Institute would be much smaller than that of any other department of the College. And the returns could be immeasurably great, to the College and to the country.



## APPENDIX 48.

*Division of Provincial Nursing Councils  
Registers.*

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NURSES REGISTER.

- A-1** Senior Certificated general-trained nurse. (Trained in her own province).
- A-2** Senior Certificated general-trained nurse. (Trained in other provinces in India).
- A-3** Senior Certificated general-trained nurse trained ex-India.
- 
- B-1** Junior Certificated general-trained nurse. (Trained in her own province.)
- B-2** Junior Certificated general-trained nurse. (Trained in other provinces in India.)
- 
- C-1** Senior Certificated nurse trained in Women & Children. (Trained in her own province.)
- C-2** Senior Certificated nurse trained in Women & Children. (Trained in other provinces.)
- 
- D-1** Junior Certificated nurse trained in Women & Children. (Trained in her own province.)
- D-2** Junior Certificated nurse trained in Women & Children. (Trained in other provinces.)
- 
- E-1** Senior Certificated male nurse. Trained in his own province.
- E-2** Senior Certificated male nurse. Trained in other provinces.
- 
- B-1** Junior Certificated male nurse. Trained in his own province.
- F-2** Junior Certificated male nurse. Trained in other provinces.
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MIDWIVES REGISTER.

- A-1** Nurse-Midwife (Senior double certificated) trained in her own province.
- A-2** Nurses-Midwife (Senior double certificated) trained in other provinces.
- A-3** Nurses-Midwife (Senior double certificated) trained ex-India.
- 
- B-1** Nurse-Midwife (Junior double certificated) trained in her own province.
- B-2** Nurse-Midwife (Junior double certificated) trained in other provinces.

C-1	Midwife senior certificated.	Trained in her own province.
C-2	" "	Trained in other provinces.
C-3	" "	ex-India.

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D-1	Midwife junior certificated.	Trained in her own province.
D-2	" "	Trained in other provinces.

#### HEALTH VISITORS REGISTER.

A-1	Nurse health visitors.	Trained in her own province.
A-2	" "	Trained in other provinces.
A-3	" "	Trained ex-India.

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B-1	Health Visitors	Trained in her own province.
B-2	"	Trained in other provinces.



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# APPENDIX 49.

## *Roll of Assistant Nurses—A.C.I. 1532, Nurses Act, 1943.*

1. Under the authority of the Nurses Act, 1943, the General Nursing Council for England and Wales forms and keeps a roll of Assistant Nurses and makes rules for the formation, maintenance and publication of the Roll and regulates the conditions of admission to the Roll.

2. The " Rules and Schedules to the Rules for Existing Assistant Nurses and Assistant Nurses with Intermediate Qualifications framed by the General Nursing Council for England and Wales under Part I of the Nurses Act, 1943 " have now been published.

3. Under those Rules every person who desires to obtain admission to the Roll as an Existing Assistant Nurse must apply within two years after 4th February 1944, on which date Part III of the Rules came into operation. Applicants must produce evidence that they have had specified periods of whole-time training or experience before 17th March, 1943 in the nursing of the sick under the supervision of trained nursing staff in a hospital or institution.

4. Those who are not qualified to obtain admission to the Roll as an Existing Assistant Nurse must apply before the date on which Rules relating to training and examination made under the Act come into operation. This date has not yet been decided but in all probability will be 31st December, 1946. Such applicants must produce evidence that before the date on which the rules relating to training and examination come into operation, they have had specified periods of whole-time training or experience in the nursing of the sick under the supervision of trained nursing staff in a hospital or institution.

5. Every R.A.M.C. other rank, A.T.S. auxiliary, V.A.D. member, or any other army personnel with nursing and midwifery training, or experience, who desires to apply for admission to the Roll of Assistant Nurses, should study the Rules referred to in para. 2 above, copies of which can be obtained from the General Nursing Council for England and Wales, 23, Portland Place, London, W. 1. (Price 1s. 0.) In the case of medical units it is suggested that one or more copies be obtained by the O.C. Unit by applying to C. 2 (c) (Books), War Office and that the rules regarding admission to the Roll be explained to all interested personnel.

6. It is important that applications for admission to the Assistant Nurses Roll be received at the General Nursing Council for England and Wales before the expiration of the periods of grace referred to above.

(A summary of this A.C.I. is No. 113 in the series " Notice Board Information ".)

## APPENDIX 50.

*Composition of the Proposed Central Nursing Council.*

1. *President of the Council.*—Director General, Indian Medical Service, in the first instance, and later elected by the Council from amongst its members.

*Members.*

2. Chief Lady Superintendent, Auxiliary Nursing Service, Member & Secretary, Office of the D.G., I.M.S. . . . .	1
3. The Assistant to the Surgeon General (Nursing), Madras . . . . .	1
4. One Certified Nurse representing training schools for nurses deputed by each Provincial Nursing Council . . . . .	10
5. A senior member of the Nursing Profession working in each of the following areas— Delhi Province, N.W.F.P., Baluchistan and Central India . . . . .	4
6. President of the Trained Nurses Association of India . . . . .	1
7. Director of the School of Nursing Administration . . . . .	1
8. Chief Principal Matron, Medical Directorate . . . . .	1
9. The Lady Superintendent, Lady Reading Health School, Delhi . . . . .	1
10. The Chief Lady Superintendent, Lady Minto's Indian Nursing Association . . . . .	1
11. The Public Health Commissioner with the Government of India . . . . .	1
12. The Director of Maternity and Child Welfare, Indian Red Cross Society . . . . .	1
13. The Administrative Medical Officers or the Directors of Public Health in 10 Provinces . . . . .	10
14. 4 members nominated by the Governor General-in-Council, 1 of whom must be Registered Nurse (Ward Sister) and 1 Health Visitor : the other 2 preferably ladies with distinguished records of service for the advancement of women's interests . . . . .	4
15. 1 member of the Educational Service, preferably Inspectress of Schools . . . . .	1
16. It will be seen that this membership includes 23 members of the nursing profession, 12 members of the medical profession exclusive of the President, and that wider aspects of advancement of women and education is also secured.	

It should not be a matter of great difficulty to provide a complete and representative Executive Committee from its members.

## APPENDIX 51.

*Composition of the Central Pharmaceutical Council.*

## A PRESIDENT

Eleven members—one nominated from each Provincial Council.

In addition, representatives of the medical profession should be included and it will be essential to ensure adequate representation of the pharmaceutical teaching profession.

A permanent Secretary and probably a permanent legal adviser will be required.

*Composition of a Provincial Pharmaceutical Council.*

A President, to be elected by the members at their first meeting.

14 members representing the pharmaceutical trade, education and other pharmaceutical interests. These members should be, in the first instance, elected by the teaching institutions, local pharmaceutical bodies and chambers of commerce. One member should be a medical practitioner.

A Permanent Secretary.



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## APPENDIX 52.

## PHARMACY AND POISONS ACT, 1933.

*Removal of Pharmacists from Register (U.K.)*

(1) If a registered pharmacist, or a person employed by him in the carrying on of his business has been convicted of any such criminal offence, or been guilty of such misconduct as, in the opinion of the \*Statutory Committee, renders him, or in the case of an employee, would, if he were a registered pharmacist, render him unfit to be on the register, the committee, after making inquiry into the case, may, subject to the provisions of this Act, direct the registrar to remove the name of the pharmacist from the register.

(2) If the Statutory Committee thinks fit in any case so to do, it may, either of its own motion or on the application of the person concerned, direct the registrar to restore to the register, either without fee or on payment of such fee, not exceeding the fee payable on registrations [as a pharmacist, as may be prescribed by byelaws, any name or entry which has been removed from the register ;

Provided that, where an appeal to the High Court against the removal of a name from the register has been dismissed by the High Court, a direction under this sub-section in respect of that name shall not take effect unless approved by the Privy Council.

(3) The power of the \*Council to remove members from the Society and the power of the Privy Council to direct the removal of names from the register shall cease, but nothing in this section shall affect the provisions of ten, eleven and twelve of the Pharmacy Act, 1868, with respect to the erasure from the register of names and entries in the cases to which those sections respectively relate.

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\*NOTE.—The 1933 Act established the Statutory Committee and vested in it certain of the powers previously held by the Council as a whole.

## APPENDIX 53.

## CATEGORIES AND TYPES OF MEDICAL AND ANCILLARY PERSONNEL THAT WILL BE AVAILABLE ON DEMOBILISATION.

## CATEGORY I—MEDICAL OFFICERS (MALE &amp; FEMALE)—

## TYPES—

"A" Those with Higher Qualifications such as *Types of Employment for which suitable*—

- F. R. C. S. . . . . (a) General Medical employment  
 M. S. . . . . (b) Public Health work and Administration  
 M. R. C. P. . . . . (c) Specialist appointment on the staffs of teaching hospitals.  
 M. D. . . . . (d) Higher teaching posts in Medical Colleges and Schools.  
 M. R. C. O. G. . . . .  
 D. P. H. . . . . (e) Research work  
 D. M. R. E. . . . . (f) Superintendents of Mental Hospitals, Sanatoria (T. B. Leprosy), Institutes of Hygiene and Pathological Laboratories.  
 D. O. . . . .  
 D. O. M. S. . . . . (g) Lectures in Physiology at Universities or Colleges appointments in Public Health Departments or in clinical Laboratories.  
 D. L. O.  
 D. P. M.  
 D. O. G. . . . .  
 D. B., etc., etc.

In recognised cadres of Government Service, Municipal Boards, District Boards, Indian States, Railway Medical Service, Dufrin Fund Service, Mission Hospitals and Large Public hospital.

"B" Recognised as Specialists in one or other of the following subjects:—

- Anaesthetics . . . . .  
 Dermatology . . . . .  
 Gynaecology . . . . .  
 Hygiene including Malariology, Medicine.  
 Mental Diseases . . . . .  
 Ophthalmology . . . . .  
 Diseases of E. N. & T. . . . .  
 Pathology . . . . .  
 Radiology and Surgery . . . . .  
 Malariology . . . . .  
 Neurology . . . . .  
 Venereology . . . . .  
 Physiology . . . . .

Recognised Specialists with higher academic qualifications will fall automatically under Type "A".  
 Recognised Specialists without higher academic qualifications will fall automatically under Type "C".

"C" Graded Specialists in one or the other of the subjects mentioned under Type "B".

- (a) Public Health Work including Malariaology .  
 (b) Research work .. ..  
 (c) Teaching posts in Medical Colleges and Schools ..  
 (d) Specialists in non-teaching hospitals ..  
 (e) Mental Asylums .. ..  
 (f) T. B. Sanatoria, hospitals and Clinics ..  
 (g) Lepet Asylums, hospitals and Clinics ..  
 (h) V. D. hospitals and Clinics .. ..  
 (i) Institutes of Hygiene and Pathological Laboratories.

"D" Graduates .. ..

- (j) Junior lecturers in Physiology and appointments in Clinical Laboratories. ..  
 (a) General Medical Employment .. ..  
 (b) School Medical Officers .. ..  
 (c) Child Welfare and Maternity Centres ..  
 (d) Staff appointments in Sanatoria (T. B. and Leprosy).  
 (e) Subsidized Practitioners and M. Sc. for Rural Development Schemes.

- (f) Tea Gardens .. ..  
 (g) Shipping Companies .. ..  
 (h) Factories and Mills .. ..  
 (a) Public Health Work .. ..  
 (b) Rural and Urban M. O. Hs. .. ..  
 (c) School Medical Officers .. ..  
 (d) Child Welfare and Maternity Centres ..

"E" Licentates (with L. P. H. or D. T. M. qualification).

"F" Licentates .. ..  
 "G" Nutrition experts .. ..

- Employment as under "D"  
 Appointments in Public Health Organizations, Relief Organizations, Physiology Departments of Universities, Colleges, large hospitals, Research Laboratories.  
 On Blood Transfusion work in Universities, etc. ..

"H" Blood Transfusion Officers.

CATEGORY II—DENTAL OFFICERS (I.A.D.C.)—  
 Types : (1) Those with U. K. qualifications

- Teachers in Medical College and Schools  
 &  
 Appointments as Dental Officers in Hospitals.

(2) Those with Indian qualifications

In recognised cadres of :—  
 Government Service,  
 Municipal Boards,  
 District Boards,  
 Indian States,  
 Railway Medical Service,  
 Dufferin Fund Service,  
 Mission Hospitals, and Large Public hospitals.

In recognised cadres as mentioned above.

In recognised cadres of :—  
 Government Service,  
 Municipal Boards,  
 District Boards,  
 Indian States,  
 Railway Medical Service,  
 Mission Hospitals, and Large Public hospitals.



### CATEGORY III—Nurses—

#### Types :

1. *I.M.N.S. (T) & (R)—  
A.I.N.S.R. and Trained Nurses  
of the A. N. S.*

These consist of personnel fully trained in the Medical and Surgical Nursing of men, women and children, and are state registered either in India, the U. K., or the British Dominions and Colonies.

#### Types of employment for which suitable.

1. Inspectresses of Nursing Services under Government.

2. Appointments as :—

- (a) Matrons of hospitals (after further special training)
- (b) Sister Tutors (after further special training)
- (c) Sisters. . . . .
- (d) Staff Nurses . . . . .
- (e) Health Visitors (after further special training)
- (f) District Nurses . . . . .
- (g) Sanatoria Nursing Staff . . . . .
- (h) Infectious Diseases hospitals Nursing Staff . . . . .
- (i) Nurses in Infant, Child Welfare and Maternity Centres (after further special training).
- (j) Nurses in T. B. Clinics (Female).
- (k) Nurses in V. D. Clinics (Female).
- (l) Nurses in Mental hospitals (after further special training).

In recognised cadres of :—  
Government Service,  
Indian States,  
Railways Medical Service,  
Municipal Boards,  
District Boards,  
Dufferin Fund Service and Public Hospital  
Private Hospitals and Nursing Homes.

2. *Male Nurses—*

These are fully trained Nurses registered by the Provincial Nursing Registration Councils and directly recruited as V. C. Os. in the Army.

In recognised cadres of :—  
Government Service,  
Indian States,  
Railway Medical Service,  
Municipal Boards,  
District Boards, and Public Hospitals,  
Private Hospitals and Nursing Homes.

3. Uncertificated partially trained female Nurses employed in the Army under the A. N. S. Scheme.

Only suitable as Probationer Nurses in hospitals which are training schools to enable them to complete their training. When certificated, they can be employed as detailed under item 2 of Type 1.

# **CATEGORY IV.—TECHNICIANS—**

## **TYPES:**

### **1. Radiographer—**

- Class III Four months' intensive training.  
 Class II Six months' training ..  
 Class I Nine months after completion of the Course for Class II and passing that examination.

Syllabus of the training as at Appendix "F"

- (a) X-Ray Departments of hospitals, or  
 (b) For further training necessary for such appointments in the Civil.

### **A. Classes accepted for the above courses :**

- (a) Directly recruited V. C. Os.  
 (b) Specialist Improvers.

### **2. Laboratory Assistants—**

- Class III Four months' intensive training and examination.  
 Class II After Six months' intensive training and satisfactory result.  
 Class I After nine months Do.  
 Classes accepted for the above courses :—  
 (a) Directly recruited V. C. Os.  
 (b) Specialist Improvers.

Syllabus of the training as at Appendix "G"

- (a) Employment in Pathological Laboratories in Colleges and Institutes, and Hospitals Laboratories, or  
 (b) For further training necessary for such appointments in Civil.

### **3. Compounders—**

- Classes accepted by the Army—  
 (1) Fully certificated from Provinces

For employment as Compounders, etc.



4. <i>Specialists Improvers (Male)</i> — These consist of a class educated up to the 9th standard who have received further Army training.	Syllabus of the training as at Appendix "A" ..	Suitable for employment as Probationer Nurses in hospitals which are training schools to enable them to complete their training and obtain civil registration. When certificated, they can be employed in the appointments mentioned for Type 2.
5. <i>Nurses Orderlies</i> — (a) With Military Nursing Diploma (24 months' course).		A certain number of this class will be suitable as Probationers in training schools to qualify as Male Nurses and to enable them to complete their training as Civil Male Nurses. When certificated, they can be employed in the appointments mentioned for Type 2.
(b) With 3rd Grade Nursing certificate. (c) With 2nd Grade Nursing Certificate. (9 months' course). (d) With 1st Grade Nursing Certificate	Syllabus of the training as at Appendix "B" ..	Do. and for hospitals employing uncertified Nurses. Do. For Hospitals employing uncertified Nurses.
(e) Special Treatment Orderlies, (V. D.) Must have 2nd Grade Nursing Certificate and 3rd Class Roman Urdu Certificate of Examination with clinical training in V. D. Course 3 months.	Syllabus of the training as at Appendix "C" ..	Do. For V. D. Hospitals and Clinics.
(f) Mental Nursing Orderlies. 3 months' course—Education and Nursing Certificate as under (e).	Syllabus of the training as at Appendix "D" ..	For Mental Asylums and Clinics.
(g) Operations Room Attendants (4 months' course.) Nursing certificate as under (e). 3rd Class certificate of education in English.	Syllabus of the training as at Appendix "E" ..	For large general hospitals.
(h) Ophthalmic Orderlies. (3 weeks' course.) Minimum qualifications required 2nd Nursing Certificate & 3rd Class English Certificate of Education or A. V. VI.		
(i) Dental Orderlies .. ..		
(j) Masseuse .. ..		

## APPENDIX "A".

## INDIAN ARMY MEDICAL CORPS (NURSING SECTION).

1. Indian Hospital Corps was transferred en-bloc to the I.A.M.C. or formation of the latter—3 April, 1943.

2. A. I. (I) Special 114/43 is the authority for Terms of Service, pay, etc. of all ranks and categories of the I.A.M.C.

3. *Nursing Section* (Composition).

Viceroy Commissioned Officers, V. C. Os.—Subedar-Majors, Subedars, Jemadars. The V. C. Os. include Radiographers, Laboratory Assistants, and Male Nurses. Suitably qualified men can be directly recruited as V. C. Os.

*Male Nurses.* Qualifications required.

Civil Nursing Diploma and registration in Provincial register.

Directly recruited Male Nurses are automatically graded as Grade I for Grade Pay of Rs. 60 p.m. in addition to pay of rank.

*Laboratory Assistants and Radiographers.*

B. Sc. with special subjects, equivalent scientific qualifications or practical experience.

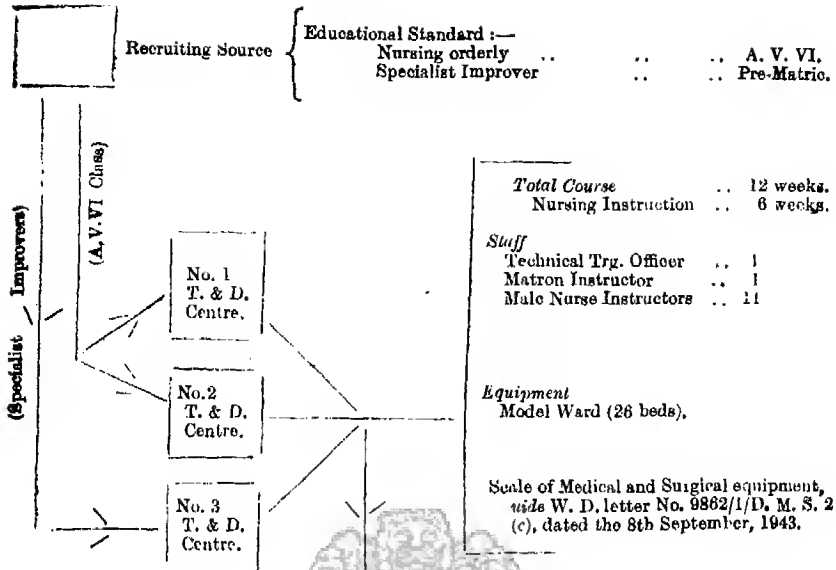
Radiographers in possession of Certificate of Radiographical Assistant Madras are also graded as Grade I.

Other Radiographers and Laboratory Assistants appear before a Trade Testing Board and on the results are graded I, II or III according to their qualifications.

*Rank and File.*—Minimum educational standard required for recruits to the Nursing Section is Anglo-Vernacular VI.

*Pay.*—Rs. 18 p.m. basic pay (Sepoy) and training allowance of Rs. 18 p.m.

*Specialist Improver Class.*—In addition to the ordinary Nursing Orderly a new Class called Specialist Improver Class has been introduced. These personnel are recruited from the pre-matriculation class and received, in addition to basic pay of Rs. 18 training allowance of Rs. 32 p.m. which gives them a total of Rs. 50 p.m. They intended for special training as Laboratory Assistants, Radiographers and Male Nurses and for eventual promotion to V. C. O. rank.



A. 1. *Training in selected Hospitals.*

(a) 1st and 2nd Nursing Certificates :—

1st Nursing Certificate	.. 2 months.
2nd Nursing Certificate	.. 4 months.

(b) *Staff.*

Training Officer appointed by O. C. hospital, *vide* these Headquarters letter No. 10001/D. M. S. 1(f) of 12th April, 1943.

Hospital Matron assisted by selected Sister (M. N. S.)

Two Male Nurse Instructors.

(c) *Equipment.*

*Vide* (Under issue).

(d) *Syllabus.*

*Vide* these Headquarters letter No. 10001/D. M. S. 1(f), dated the 12th April, and 16th August, 1943.

2. 3rd Nursing Certificate :—

6 months, training.

3. Military Nursing Diploma :—

9 months' training.

B. Specialist Improver class undergo training upto 2nd Nursing Certificate in selected hospitals in Southern Army, after which they are available for posting to selected hospitals in other Armies/Command, *vide* letter No. 10001/11/D. M. S. 1 (f) of 27th January, 1944.

**G. A. V. VI** standard are posted to selected hospitals in all Armies/ Commands less Eastern Command and 14th Army. They are retained in these hospitals upto the 2nd Nursing Certificate on completion of which they are available for posting to other hospitals and field medical units, *vide* No. 10001/ D. M. S. 1 (f) of 10th November, 1943.



## APPENDIX "B".

## SYLLABUS FOR MILITARY NURSING DIPLOMA (AT THE END OF 24 MONTHS).

*Surgical Lectures.—*

1. Nursing of compound fractures. Effects of pressure. Care of sprains and dislocations.
2. Nursing of Ear, Nose and Throat cases. Preparation for operation and after nursing care. Syringing of ears.
3. Nursing of eye cases. Preparation for operation. After care. Feeding and nursing of eye injuries.
4. Preparation of cases for various examinations. Cystoscopy. Sigmoidoscopy. Rectal wash out. Care of Haemorrhoid cases and other Rectal operation cases.
5. Preparation for X-Ray examination. X-Ray treatment. Radium.
6. Preparation for anaesthetic table. Special requirements for local general, spinal, rectal, intravenous anaesthesia. Preparation for Lumber puncture.
7. Preparation of operating theatre. Cleansing of theatre. Cleansing of theatre prior to operations. Use of steam sterilizers. (High pressure) Preparation of ligatures and sutures, tubes, dressings, plugging and lubricants.
8. Instruments in use for various operations. Methods of sterilizing same. Treatment of electrical appliances in common use.
9. Sharp instruments, their care and preservation. Method of sending specimens for examination.
10. Special method packing drums for operation theatre use. Treatment of gloves and other rubber appliances.
11. Duties of Orderly in operating theatre. Qualities to be displayed, observation, promptness, quiet efficiency to be elaborated. Position of patient, etc.
12. Nursing of the more severe burns and scalds.
13. Inflammation, suppuration, ulceration gangrene.
14. Nursing of cases of injuries to and diseases of joints.

*Medical Lectures.—*

1. Nursing of acute infectious fevers. Scarlet fever, Measles, Chicken-pox, Mumps, Small-pox.
2. Nursing of Diphtheria, complications which may arise. Nursing of Tracheotomy cases.
3. Nursing of Cerebro-spinal meningitis. Lumber puncture. Injections of anti Toxins.
4. Nursing of diseases affecting the nervous system, Meningitis, Myelitis, Apoplexy, Epilepsy, Hysteria, Neurasthenia.
5. Nursing of tropical disease, Enteric (Typhoid fever) Paratyphoid.
6. Nursing of tropical diseases continued, Typhus, Plague, sandfly fever, Dysentery, Malaria.

7. Nursing of heat stroke, severe cases of heat exhaustion. Dengue cholera, sprue.

8. Nursing of diseases of the pancreas and liver. Jaundice, liver abscess, diabetes. Special diets.

9. Diseases resulting from Faulty nutrition, Beri-beri, scurvy.

10. Nursing of diseases of the mouth, throat and stomach.

11. Nursing and treatment of skin cases, ringworm, eczema, scabies, impetigo.

12. Administration and action of drugs.

#### *Lecture and Instruction.*

1. Surgery of the abdomen, amputations. Haemorrhage; primary, reactionary and secondary. The healing of wounds.

2. Shock, intravenous infusions. Blood transfusion.

3. Burns. First aid treatment; treatment in hospital.

4. Contents of Nos. 1 and 2 Field Ambulance Panniers. Surgical instruments description, sterilization and cleaning of.

5. Definitions—hygiene, sanitation, conservancy. Causation of disease.

6. Environment in relation to hygiene; clothing, climate, work, rest, personal hygiene. Diseases resulting from environment.

7. Germs—origins, species. The chain of infection. Prevention of and protection against disease.

8. Water supplies—water-borne diseases. Food supplies, food diseases and their prevention.

9. Excremental diseases.

10. Droplet infections.

11. Diseases transmitted by animals.

12. Diseases transmitted by personal contact-exposure-injury.

13. Disinfection.

14. Chemical warfare. Nursing and treatment of gas casualties. Defensive measures.

15. Poisoning. General lines of treatment.

16. Medicines and their administration. Action of some of the commoner drugs.

17. Enemata; remedial applications; baths, packs.

18. Diseases of the heart and pericardium.



**SYLLABUS FOR 3RD GRADE NURSING CERTIFICATE (AT THE END OF 15 MONTHS).**

***Surgical.***—

1. Qualifications of a good Surgical Nurse. Asepsis, Sterilization of appliances used. Preparation of syringes, lotions, lubricants, tubes, plugging, drains, etc.

2. Nursing of clean and dirty surgical cases. Method of arranging work. Correct method of carrying out a dressing, clearing up, etc. Use of drainage tubes changing same. Removal of sutures.

3. Preparation of patient for (a) Anaesthetic (b) Operation. Special preparation for various cases, and special after care required.

4. Special preparation for bone operations to be elaborated salines, rectal intravenous, continuous drip.

5. Preparation for and after nursing of cases under Spinal anaesthesia. Complications which may arise.

6. Elaboration of preparation and after nursing of abdominal, head, chest, rectal and operations.

7. Spinal injuries, admission of, nursing of and special operations connected therewith.

8. Nursing of cases of severe gunshot wounds. Methods of resuscitation. Care of septic wounds. Treatment of shock.

9. Haemorrhage, Primary, Secondary. Signs and symptoms. Treatment.

10. After nursing of amputation cases. Use of tourniquet. Blood transfusion.

11. Nursing of gastric cases. Feeding Diet scales.

***Medical.***—

1. Ward management. Admission of patients. How extras are drawn. Hygiene and feeding of patients.

2. Observation of the sick elaborated. Importance of clear and concise reports. Position in bed, movement of patients. Disposal of the dead.

3. Diets in various diseases. Laying of trays. Preservation of food.

4. Enemata stimulant, sedative, nutrient, drip continuous, details of appliances used.

5. Incontinence retention, suppression of urine. Nursing cases of Cystitis Pyelitis, Nephritis.

6. Urine testing. Demonstration.

7. Nursing of diseases of the respiratory system Pneumonia, Bronchitis, Pleurisy, Pleural effusion.

8. Potai's Aspirator, Aspiration of fluid. Demonstration of Aspirator.

9. Nursing care of Heart cases and acute rheumatism.

10. Nursing of gastric cases. Test Meal. Stomach lavage, Barium Meal.

11. Nursing cases of Tuberculosis. Feeding. Disinfection of utensils.

**LECTURES TO BE DELIVERED BY MEDICAL OFFICERS IN CON-  
JUNCTION WITH THE SYLLABUS OF TRAINING.**

1. Burns and scalds, shock, loss of consciousness and fits.
2. The eye and ear (elementary).  
Suffocation. Electric shock and special similar conditions. Effects of cold.
3. Drowning ; rescue and resuscitation. Poisoning. Infectious diseases. Personal hygiene of the nursing orderly. Disinfection.
4. Revision of skeleton ; composition of structure of bone, cartilage, ligaments and joints. Surgical anatomy and surgery of head, face and spine.
5. The muscular system. Structure and function of muscles. Muscular development. Internal work done. Energy and heat.
6. The cavity of the thorax, situation and functions of contents. The systemic circulation, blood vessels ; composition and function of the blood. The spleen.
7. The respiratory system ; air and food passages. Mechanism of respiration ; the pulmonary circulation. Surgery of the chest, empyema tracheotomy.
8. The cavities of the abdomen and pelvis. The digestive system, alimentary tract, teeth, glands, peristalsis, food and nutrition ; the portal circulation.
9. Diseases and surgery of the rectum ; comparison of natural and artificial feeding. The urinary system and prostate.
10. Suppression, incontinence and retention of urine. Catheters and catheterization (to include practical instruction in the passage of soft rubber catheters). Urine testing.
11. The nervous system ; brain and spinal cord ; nerve cord and endings ; the sympathetic system ; reflex action. Surgery of nerves.
12. Anatomy and functions of the organs of the special senses ; eye ; nose, tongue, ear and larynx ; removal of foreign bodies ; elementary surgery.
13. The lymphatic system ; lymph, lymphatic glands and channels. Sepsis.

**SYLLABUS FOR 2ND GRADE NURSING CERTIFICATE (AT THE END  
OF 9 MONTHS).**

***Elementary Nursing.*—**

1. Ward management, ventilation, methods of cleaning and care of ward equipment ; admission of patients, disposal of Kit ; taking of patient's particulars, etc. Giving of bedpans and urinals.
2. Disposal of soiled linen and dressings. Disinfection of infected linen, etc. Hospital etiquette and discipline.
3. Bedmaking. Special beds, Rheumatism, Heart Fracture, Operation, Accident. Lifting and turning of patients. Preparation of air and water beds (to be demonstrated).

4. Admission of stretcher cases. Hygiene of patient. Washing, feeding and treatment of helpless cases. Pressure sores and their prevention.

5. Observation of the patient. Position, expression, colour, secretions, excreta, expectoration, appetite, delirium, sleep.

6. Observation of pt. cond't; Temperature, pulse, respirations, charting same. Recording of intake and output in special cases. Method of accurate note taking. Reports verbal and written.

7. Administration of medicine, inhalations, administration of oxygen. Lotions, varieties and strengths. Weights and Measures in common use, domestic equivalents. Demonstrations.

8. Administration of gargles, painting of throats. Application of eye lotions and drops. Use of.

9. Preparation of various kinds of poultices, antiphlogistine, fomentations medical and surgical. Hot water bottles their uses and dangers. Use of ice bags, method of filling and applying. Soap and water enema. Demonstration.

10. Pyrexia and Hyper-pyrexia, nursing of, Rigors treatment of, Nursing of non-infectious fevers.

11. Responsibilities regarding saving of specimen of urine, stools, sputum, vomit. Care of foreign bodies discovered in specimens. Disposal of infected specimens. Demonstration.

12. Nursing of infectious cases. Isolation. Disinfection of linen, excreta, etc. Personal belongings of patient and how to render all free from infection. Disinfection of hospital equipment and utensils.

13. Methods of reducing temperatures. Sponging. Baths various cleaning, medicated, hot air, local.

14. Surgical cleanliness. Cleansing and sterilization of instruments, mackintoshes, catheters, gloves, Dressing trolley requirements. Drums, how to pack and use. To be demonstrated.

#### LECTURES TO BE DELIVERED BY MEDICAL OFFICERS IN CONJUNCTION WITH THE SYLLABUS OF TRAINING.

##### *2nd Grade Nursing Certificate.*

1. The construction of the human body. The skeleton. Recognition and description of the principal bones; cartilages, ligaments and joints.

2. The muscular system. Structure and function of muscles. The cavities formed by the skeleton and their contents.

3. The circulatory system; the heart and blood vessels; the blood. The spleen.

4. The respiratory system; the organs of respiration, their structure, functions. Composition of air. The air and food passages.

5. The digestive system; the alimentary canal and digestive glands. the teeth. The digestion of food.

6. The nervous system ; the brain and spinal cord, motor, sensory and sympathetic nerves.
7. The excretory system. The lymphatic system.
8. Wounds and their treatment. Antisepsis and asepsis. Dressing and healing of wounds.
9. First Field and Shell Dressings. Instruments, Contents of Surgical Haversack and Medical Companion.
10. Haemorrhage.
11. Fractures and their treatment.
12. Fractures (continued) ; special fractures and splints. Dislocations and sprains.

*Syllabus for 1st Grade Nursing Certificate.*

This can be obtained at the end of the 2 weeks' Recruits Training ; duration of the Course 6 weeks.

SYLLABUS.

Elementary Anatomy and Physiology and First Aid.

Types of Hospital cases.

Hospital ward furniture and appliances.

Ward administration—bed linen, etc.

Bed-making, etc.,—moving of patients.

Drugs—methods of administration. Poisons.

Poultices, fomentations, plasters etc.

Fevers—taking of temperature. Charts.

Taking and recording of pulse and respiration.

Toilet—bed sores.

Disposal of excreta (Field Service Hygiene notes).

Special appliances (enemas, catheters, stomach tubes).

Instruments and dressings used in the ward.

Sepsis and asepsis—wound infection.

Antiseptics, sterilization and disinfection.

Baths and sponging of patients.

Restoration methods—shocks.

Nursing emergencies—haemorrhage, collapse.

Use of Plaster of Paris—plaster technique.

Taking and disposal of specimens for laboratories.

In addition, Lectures and Instruction will be given in the following :

Common infectious cases.

Nursing of fever cases.

Nursing of skin cases.

Nursing of special cases—heart, pneumonia, etc.

Pre-and post-operative treatment.

Burns—nursing and care of.

Nursing of fracture cases.

Ear, nose and throat and eye cases.

Diets and feeding.

Observation of patients.

Use of enema, catheter, stomach tube, etc.

Urine testing.

Management of cases of heat-stroke.

## APPENDIX "C".

*Special Treatment Orderlies (Indian).*

Duration of Course : 3 months.

To attend the Course, candidates must have a minimum qualification as noted below :—

(a) 2nd Grade Nursing Certificate.

(b) 3rd Class Roman Urdu Certificate of Education.

At the end of the Course an examination will be held.

SYLLABUS OF TRAINING—SPECIAL TREATMENT ORDERLIES (INDIAN).  
CLASS III.

(A) *GENERAL*.—

1. Elementary anatomy and physiology of the genito-urinary tract in the male.
2. General description of venereal diseases.
3. Grouping of patients according to diseases. Latrines and bath accommodation. Ward discipline.
4. Marking and disinfecting clothing. Method of dealing with clothing of venereal patients. Feeding utensils.
5. General duties of a special treatment orderly.
6. Action for the admission and preliminary treatment of a patient suffering from V.D.
7. Procedure regarding continuation of treatment as an out-patient in the army or as a civilian following discharge from the army.
8. Description of a P. T. Room.
9. Duties of the orderly i/c. P. T. Room.
10. Description of common skin diseases, their treatment and nursing.

(B) *SYPHILIS*.—

1. General description of syphilis, causes and mode of infection.
  2. Method of taking specimens for laboratory examination.
  3. Method and reason for taking blood.
  4. General and local treatment with special reference to nursing.
  5. Preparation of patient for specific treatment. Method of administration.
  6. Duties in the treatment room as regards minor operations, dressings and local applications.
  7. Soft Chancre
  8. Climatic Buboe
  9. Herpes Genitalis
- } Brief description.

(C) *GONORRHOEA*.—

1. General description of gonorrhoea, causes and mode of infection.
  2. Treatment with special reference to nursing and care of complications.
  3. Description and uses of instruments.
  4. Instruction in irrigation room.
  5. Prevention and treatment of gonorrhoea ophthalmia.
  6. Urethrites Simloex
  7. Phimosis and Paraphimosis
  8. Venereal Wards
- } Brief description.

**D) LABORATORY ROUTINE.**—*If time permits.*

1. Glass ware—care of glass, microscope slides, test-tubes, etc.
2. The microscope—mechanism, care and maintenance.
3. The Chemical Balance—care and maintenance.
4. Preparation and sterilisation of solutions.
5. Description of training in smears.

Intensive training in V.D. Wards for a period of 12 weeks when not attending lectures.



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## APPENDIX "D".

*Mental Nursing Orderlies (Indian).*

Duration of Course : 3 months.

To attend the Course, candidates must have a minimum qualification as noted below :—

(a) 2nd Grade Nursing Certificate.

(b) 3rd Class Roman Urdu Certificate of Education.

During the period of training, personnel will be employed only in psychiatric wards and will undertake general and specialist nursing duties in these wards.

On the termination of the Course, a report will be submitted.

## SYLLABUS.

## SECTION A.

## THE MIND IN HEALTH.

1. *Psychology*.—Definition, mind and body—relationships ; instincts and reflexes ; three aspects of mind ; cognition (knowing), affection (feeling) and conation (striving) ; sensation, perception ; conception. Special sensations ; hearing, vision, smell, taste, skin sensations ; Visceral ; anaesthetic, apperception ; meaning, ideation ; association of ideas, imagination ; memory ; emotion ; passion, mood temperament ; volition, attention ; complex.

2. The mind conscious and unconscious—repression ; projection ; introjection ; dreams.

3. Elementary anatomy and physiology of C.N.S. brain ; spinal cord peripheral nerves.

## SECTION B.

## THE MIND IN DISEASES.

1. *Psychopathology*.—Definition. Classification ; psychoneurosis, psychosis, psychopathic states, mental deficiency.

2. *Signs and Symptoms*.—

(A) *Physiological*.

(a) Sensory ; loss, excess, perversion ; pain.

(b) Motor ; weakness, loss, inco-ordination ; tremor ; spasm, rigidity convulsion ; atrophy and hypertrophy.

(c) Reflexes.

(d) Condition of skin, muscles, bones, joints, circulatory, respiratory, elementary urinary reproductive and endocrine systems.

(e) Stigmata of Degeneration.

(f) Types of physique.

(B) *Psychological*.

(a) Sensation, analgesia, parasthesia, Changes in Visceral sensation.

(b) Perception, illusion, hallucinations—types.

(c) Ideation, diminution, acceleration, obsessions.

(d) Judgment ; delusions.

(e) Memory, amnesia—types.

(f) Affection, apathy, excess, liability ; prevailing moods : depression euphoria.

(g) Volition and behaviour, diminution, overactivity, ; disorders of behaviour, impulses, mannerisms, degradation.

(h) Speech ; mutism, disconnection, incoherence.

(i) Combinations of the above terms, as in stupor, confusion, depression.

#### SECTION C.—

##### THE EXAMINATION AND NURSING OF MENTAL DISABILITY.

1. Attitude of M. N. O. to patients.

2. Points in examination.

Attitude of patient towards examination ; personal hygiene ; general physical condition ; loss of weight, physical exhaustion. Heredity, environment ; mental stress and conflict. Recent disease or wounds. Recent history of malaria, dysentery, typhus, infestation, nutritional deficiency ; heat exhaustion, alcoholism ; drug addiction.

3. Management according to clinical condition *e.g.* elated, excited, noisy, destructive, violent, suspicious, resistive, confused, stuporose, depressed.

4. Observation of fits. Differential diagnosis. Malingering.

5. Methods in treatment ; simple psychotherapy (persuasion, suggestion, encouragement), sedatives ; diversional therapy. M.N.Os. duties in : narcosis, continuous narcosis, convulsant therapy, hydrotherapy, pyrotherapy.

6. Feeding of patients, oral, nasal and rectal feeding.

7. Emergencies ; attempted suicide, artificial respiration, use of stomach tube ; first aid (*e.g.* arrest of haemorrhage).

#### SECTION D.

##### GENERAL DUTIES OF M. N. O.

1. Reception of new patient ; inspection for bruises ; abrasions ; blisters and other signs of injury. Searching of patients for dangerous objects.

2. Ward discipline—general principles.

3. Bathing of patients and rules for baths.

4. Bedding and clothing—inspection, restrictions and precautions.

5. Observations of patients at nights.

6 Arrangements for actively suicidal patients.

7. Use of mechanical restraint.

8. Observation and Reports : sleep, food, weight, bowels and bladder behaviour and habits. Sleep and weight charts. Medicine (sedative) book.

9. Duties of M. N. O. in connection with transfer, discharge or death of patient. Any forms used in psychiatric ward.



APPENDIX " E ."  
*Operating Room Attendants.*  
 SYLLABUS.

GENERAL DUTIES IN AN OPERATION THEATRE.

(a) Instruction in the theory and practice of sterilization—the care and use of the commoner types of sterilizers—method of sterilizing various instruments and articles used in the operating theatre and the handling of sterile—cleansing and care of hands and nails.

(b) The care, preparation and cleaning of the operation theatre—its annexes and furniture—preparation of patients for operation and supervision of their transfer from, and to the wards.

(c) Preparation, use and storage of antiseptics and solutions in use in the theatre—the sterilization and storage of water.

(d) Preparation, use and storage of commoner kinds of ligatures and suture material—types of needles and conditions under which various types are required.

(e) Preparation of dressings ; swabs, packs etc. method of arranging and packing drums ; the care and inspection of gloves.

(f) Care and supervision of surgical instruments, rubber goods, etc.

(g) The responsibilities of the operating room attendant with regard to —

1. The patient.

2. Ascpis in the theatre.

3. Emergency apparatus (tracheotomy, transfusion and infusion sets.)

THEATRE TECHNIQUE & CARE OF PATIENTS.

(a) Care of patients during operation ; positions used in various operations ; duties in case of collapse during operations including preparation of transfusion apparatus and saline.

(b) Knowledge of contents of the various gas cylinders used in the operating theatre, their distinguishing marks, their care and maintenance; preparation of anaesthetist's table—apparatus required—duties in an emergency—artificial respiration—raising and lowering of operating table—what to do with the tongue.

(c) Preparation of patients and instruments required for special operations, *e.g.*, injection of haemorrhoids, varicose veins, cystoscopy.

(d) Duties of operating room attendants in connection with the administration of special anaesthesia—position of patients, care of patients during and after injection—local anaesthesia—solutions used and their strengths.

(e) The identification of all instruments likely to be used in the operating theatre and wards, their construction, the method of taking apart and putting together of compound instruments.

## APPENDIX " F "

Syllabuses for courses are as follows :—(Subjects as at Appendix A).

(a) *Radiographers, Class III.* Four months of intensive training.

1st month.

Subject " A " daily lectures and demonstrations.

Subject " E " lectures and demonstrations and Dark Room Work.

2nd and 3rd months.

Subject " B " daily lectures and demonstrations.

Subject " D " lectures and demonstrations.

4th month.

Subject " D " continued.

Subject " C " and " F " lectures or demonstrations.

The students will also receive instruction in office work and in the forms used and the regulations in force in military X-Ray Departments.

During the course the student will attend regularly at the X-Ray room, to learn the procedure therein.

At the end of this course the student will be required to sit for an examination in the subjects taught, those who satisfy the examiners being graded as Radiographers Class III.

(b) *Radiographer, Class II.*

Six months work in the X-Ray Department of a large hospital under a Specialist in Radiology, during which he should receive further instruction in the subjects of his first course and also instruction and lectures in subject " G ".

At the end of this six months he will have to pass an examination in the subjects above, for promotion to Radiographer Class II.

(c) *Radiographer, Class I.*

A further 9 months work in an X-Ray Department on the completion of which, if recommended by a Specialist in Radiology, he would sit for a further examination for promotion to Radiographer Class I.

## APPENDIX " A ".

## SUBJECT " A ".

*Physics.*

Static electricity. Attraction and Repulsion. Conductors and Insulators, condensers. Electrostatic measurements, Magnetism. Electric currents, direct and alternating. Electro magnetic Induction. Measurements and measuring instruments. Dynamos, electric motors and converters. Atomic physics. Electro magnetic radiations. Wave length and intensity, characteristic radiation. Absorption, scattering and filtration on radiation. Radiation Measurements.

## SUBJECT " B ".

Electrical supply and distribution. A. C. and D. C. currents. Meters. X-Ray apparatus, Coils and interrupters. Transformers and rectifiers. X-Ray tubes, gas and hot cathode, Valve, Production of X-Rays. Accessory apparatus, meters, switches. Auto-transformers, timers and stabilisers.

## SUBJECT " C "

Anatomy and Physiology. Elementary development. Bones and joints. Ossification. Surface markings. Normal appearance on radiographer of bones and of soft tissues rendered opaque.

## SUBJECT " D "

Radiography. Positioning. Localisation, stereoscopy. Special examinations. Protection.

## SUBJECT " E "

Photography, Photographical Chemistry. Developing and fixing. Dark room technique. Faults in exposure and development. Their causes and cure.

## SUBJECT " F "

Types of apparatus used in the Army in India, their construction and characteristics. Causes of and tracing of faults. Running repairs.

## SUBJECT " G "

Electro-medical apparatus. Contraction of muscles, effects of Galvanism and Faradism. Heating and its effects. Infra red rays. Ultra violet rays and their effects. Diathermy apparatus and its use.



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## APPENDIX "G".

*Syllabuses of courses are as follows:—*

*Laboratory Assistant, Class III.*—Four months of intensive training. Syllabus at Appendix "A".

At the end of this course the students will be required to sit for an examination in the subjects taught, those who satisfy the examiners being graded as Laboratory Assistants, Class III.

*Laboratory Assistant, Class II.*—A Laboratory Assistant Class III after six months continuous employment in a laboratory and if reported on as a satisfactory by the officer in charge laboratory, may be graded as Laboratory Assistant Class II.

*Laboratory Assistant, Class I.*—Before grading Laboratory Assistant Class I, the individual must have been employed in a laboratory as Laboratory Assistant Class II for 9 months.

Provided the candidates pass the qualifying examination, based on the syllabus at Appendix "B" they will be graded as Laboratory Assistant, Class I.

## APPENDIX "A".

*Syllabus of Training—Laboratory Assistant, Class III.*

*Note.*—Army laboratory Assistants are not to be judged on their theoretical knowledge of pathology, bacteriology or biochemistry, but primarily on their ability to prepare apparatus, reagents and material with unfailing reliability, so that the officer may have dependable assistant to carry out his work.

The course of instruction should therefore be designed not with the primary intention of teaching candidates bacteriology and biochemistry but rather of teaching laboratory methods and cultivating technique. The training should include, of course, elementary clinical pathology, but with the object of stimulating and maintaining the interest of the trainee.

The following is a syllabus of training for class III laboratory assistants (pathology):—

1. *Laboratory management.*—Care and custody of equipment.
2. *Sterilization methods.*—Chemical Dry heat. Moist heat. Low temperature. Filtration.
3. *Filters.*—Types of filters. Methods of testing, cleaning and sterilizing. Methods of use.
4. *Microscopy.*—The care and use of the microscope and its component parts. Micrometry. Dark-ground illumination.
5. *Culture media.*—Preparation and cleaning of glassware, etc. Maintenance of sterility. Identification of media. Preparation and standardization of basic media. Preparation of special media in common use.
6. *Stains and staining methods.*—The preparation of stains, and methods of staining, as laid down in the official publication "Laboratory Methods 1932", together with such additions as Field's stain and Pioric acid counter-stain for T. B.
7. *Pathogenic micro organisms.*—Basic knowledge of the common pathogenic bacteria and methods of cultivation, including anaerobiosis and the chief characters of *Cl. tetani* and the as gangrene clostridia.
8. *Viruses and rickettsiae.*—General outline only.

9. *Protozoa*.—Recognition of malarial parasites, amoebae, Leishmans donovan bottles and intestinal flagellates.

10. *Helminths*.—Recognition of the eggs of the common helminth ascarisancy lostoma, enterobius, trichuris, taenia, hymenolepis, schistosom. Mounting and preservation of worms and their eggs.

11. *Haematology*.—Hb estimation. Total red and white cell counts and simple differential counts. Sedimentation rates. Blood grouping.

12. *Serology*.—(a) Agglutination.

H & O types ; methods (Dreyer's and Felix's) ; preparation of agglutinating sera.

(b) Principles of Kahn and Wassermann tests ; preparation of reagents and apparatus.

13. *Vaccine preparation*.—Outline. Preparation of apparatus.

14. *Maintenance of stock cultures*.

15. *Biochemistry*.—Elementary, including urine analysis, gastris analysis blood-sugar and blood urea estimations, Vanden Bergh, cerebrospinal fluid (protein and chlorides), and faeces (fats, fatty acids, bile pigments).

16. *Urinary deposits*.—Simple microscopy.

17. *Histology*.—Preparation of tissue for sections. Cutting and staining of sections.

18. *Post-mortem technique*.

19. *Laboratory animals*.—Care, housing, feeding, breeding and handling of laboratory animals.

20. *Office work*.—Accounting for equipment, compilation of returns registration of specimens and recording results of examination.

## APPENDIX " B ",

### PART A.

#### *Syllabus of Instruction—Laboratory Assistant, Class I.*

1. *Laboratory Management and use of Laboratory apparatus*.

2. *Sterilization Methods*.—Chemical. Dry heat. Moist heat. Low temperature. Filtration.

3. *Filters*.—Types of filters. Methods of testing, cleaning and sterilizing. Methods of use.

4. *Microscopy*.—The care and use of the microscope and its component parts. Micrometry. Dark-ground illumination.

5. *Culture Media*.—Standardization of media. Preparation of the commoner media, fluid and solid, employed in routine work and also special media for the cultivation and differentiation of:—Conococci, meningococci, pneumococci, streptococci, tubercle bacilli, diphtheria bacilli, organisms of the colityphoid-dysentery groups, pathogenic anaerobes, etc.

6. *Stains and staining methods*.—The preparation of stains, and methods of staining.

7. *Pathogenic Micro-organisms and Bacteriological diagnosis*.—Study and identification of the following bacteria, special attention being paid to morphology, staining, culture, biochemical reactions and agglutination tests where applicable.

(a) *The Pyogenic Streptococci and Staphylococci, the Pneumococcus*.

(b) *Meninococcus*.—Methods of isolating, identifying and typing. Cell count of cerebrospinal fluid. Precipitin test. An outline of the Gram-negative cocci occurring as Commensals in the nose and throat.

(c) *Genococcus*.—Methods of isolation.

(d) *Diphtheria and Diphtheroids*.—Methods of isolation and identification. Virulence, tests.

(e) *Tubercle bacillus and other Acid-fast bacilli*.—Methods of isolation from sputum, urine, pus, and other material. Antiformin method.

(f) *Intestinal Gram-negative aerobic bacilli*.—Coli group. Enteric group. Food poisoning group. Dysentery group. Methods of isolation and identification.

(g) *Vibrio cholerae and allied organisms*.—Methods of isolation, identification and differentiation.

(h) *Pasturella pestis*.—Methods of isolation and identification. Preparation of laboratory animals prior to inoculation of suspected material.

(i) *Brucella group*.—Methods of isolation and identification.

(j) *The Haemophilic Bacteria and allied organisms*.—Methods of isolation and identification.

(k) *Wound Infections*.—An outline of the organisms associated with gas gangrene. Methods of anaerobic culture.

(l) *Rickettsia group*.—The Weil-Felix reaction.

(m) *Pathogenic and Commensal Spirochaetes*.—*Treponema pallidum*, *Spirochaeta recurrentis*, *Leptospira icterohaemorrhagiae*. Methods of demonstration. Laboratory diagnosis.

8. *Rabies*.—Method of obtaining brain of suspected animal. Preparation of sections from the brain. Mann's method of staining, or William's modification of Van-Gieson's method—(basic fuchsin-methylene blue).

9. *Fungi*.—The preparation of hair or scales for examination.

10. *Protozoology*.—Recognition of malarial parasites, trypanosomes, Leishman-Donovan bodies. Outline and recognition of common intestinal protozoa and cysts. Preparation and staining of films by Mayer's haemalum and Heidenhain's iron.

11. *Helminthology*.—Identification of the following helminths and their eggs:—

*Nematodes*.—*Ascaris lumbricoides*, *Anhylostomes*, *Enterobius vermicularis*, *Trichuris trichiura*.

*Cestodes*.—*Taenia solium*, *Taenia saginata*, *Taenia granulosa*, *Hymenopis hana*.

*Trematodes*.—*Schistosoma haematobium* and *Schistosoma mansoni*. Mounting and preservation of helminths.

**12. Haematology.**—Methods of obtaining blood. Methods of estimating haemoglobin. Fumeration of Red Blood Cells and Leucocytes. Preparation of stained blood films. Recognition of normal and abnormal cells. Deferentail Leucocyte count. Reticulocytes. Examination of blood for parasites. Fratility of the Red Blood Cells. Coagulation Time. Red Cell sedimentation rate. Blood grouping.

**13. Serology.**—Preparation of agglutinating serum. Agglutination tests :—Dreyer's Method and Felix Technique. Agglutinin absorption tests. Precipitin reactions.

**Wassermann Reaction.**—Outline of the principles of the test. Preparation of all apparatus and reagents.

**Kahn Test.**—Outline of the principles of the test. Preparation of all apparatus and reagents.

**14. Preparation of Vaccines.**—Method of preparing an autogenous vaccine.

**15. Maintenance of Stock Cultures.**

**16. Preparation of tissues for microscopical examination.**—Cutting and mounting sections by the paraffin method. Massons rapid method. Freezing method.

**17. Mounting and preservation of Museum Specimens.**

**18. Urinary Deposits, including cells and casts.**

**19. Laboratory animals.**—Care, housing, feeding, breeding and handling of laboratory animals.

**20. Custody of, and accounting for, Laboratory equipment.**—Compilation of returns.

## PART B.

Cleaning, assembling and construction of apparatus employed for routine chemical or biochemical examinations. Simple glass blowing. Care of all measuring instruments. Use of spectroscope, etc.

Essential principles of Chemistry, Distillation, Filtration, etc. Preparation of standard solutions, indicators, estimation of P. H., etc. Volumetric and gravimetric methods. Chemical examinations in connection with routine diagnostic biochemical tests of :—

Urine, Faeces, Blood, Cerebrospinal Fluid, Gastric contents, etc.

## APPENDIX " H ".

*Syllabus of Training for R. A. M. C./I. A. M. C. Other Ranks. Employed in Ophthalmic Units/Centres.*

## 1st week—

1. Anatomy.
2. Physiology.
3. External Diseases and their treatment.
4. Methods of treatment.
5. Nursing of Ophthalmic Patients.
6. Preparation of Operation Theatre.
7. Preparation of patient for operation.
8. Anaesthetics used.

## 2nd week—

9. Sterilisation of Ophthalmic Instruments.
10. Sterilisation of eye drops.
11. Ophthalmic Apparatus and its care.
12. Assembly of Ophthalmic Apparatus.
13. Ophthalmic lenses, neutralising of lenses measurements, for Mark III Spectacles, fitting of spectacle frames.
14. Fitting of Artificial Eyes.
15. Records Keeping—(a) Card Index. (b) Day book. (c) Spectacle Prescription Book. (d) Operation Book. (e) Monthly Returns. (f) Army Forms used in Ophthalmic work.

## 3rd week—

16. Short lecture on care of Electric Ophthalmic Apparatus and writing of same.
17. Revision.
18. Examination.



## APPENDIX "I".

## TRAINING NURSING SEPOYS AND V. C. O.'s IN MASSAGE AND REMEDIAL GYMNASTICS.

*"Syllabus".*

The course is planned to give the maximum of groundwork and practical experience in massage, remedial gymnastics and electrical treatment in the period of three months.

Each class consists of a maximum of 20 students.

During the first month there are daily lectures on anatomy, physiology and the theory of massage and exercises including practical instruction.

The last two months are devoted to practical training in the Wards and Department, as well as daily lectures.

Instruction is carried out by qualified C. S. of P. Instructors.

The final examinations will be held at the conclusion of the course and a certificate issued to those students who pass the examinations.

The syllabus of lectures consist of :—

(1) *Anatomy—*

- (a) A careful study of the bones of the body, their shape and function.
- (b) The names, origin, insertions and functions of the main muscles and muscle groups.
- (c) A working knowledge of the joints of the body.
- (d) An elementary knowledge of the main nerves.

(2) *Physiology—*

The elementary knowledge of the structure and functions of the body and its various organs.

(3) *Theory of massage and remedial gymnastics.*

- (a) Types of massage and their uses.
- (b) Its application to wounds, fractures, dislocations, sprains, synovitis, internal derangement of the knee, bruises, scarerheumatic diseases. A. P. M. and nerve lesions.
- (c) Remedial exercises—value, restrictions and types of movement. Conduct of remedial exercise classes.
- (d) Technique of breathing exercises.

*A.*(4) *Instruction in the use of simple electrical equipment.**B.*(5) *Simple electrical treatments.*(6) *Elementary plaster work.*(7) *Instruction in splints and slings, Exercises, in Plaster splints. The use of remedial apparatus including slings and pulleys.*(8) *Instruction in English.*

## APPENDIX 54.

## ESTIMATES OF COST.

*Estimates of cost of NON-RECURRING expenditure during the first five years, second five and first ten years.*

	First five years. Rs.	Second five years. Rs.	First ten years. Rs.
Three-million unit scheme ..	75,16,83,000	1,11,16,87,250	1,86,33,70,250
Malaria Organisation .. ..	9,16,800	11,10,000	20,26,800
Tuberculosis .. ..	2,42,35,000	3,74,10,000	6,16,45,000
Mental Diseases .. ..	1,87,00,000	2,22,00,000	3,89,00,000
Leprosy .. ..	1,45,00,000	1,40,00,000	2,85,00,000
School Health .. ..	1,32,000	..	1,32,000
Nutrition .. ..	6,05,000	..	6,05,000
<b>Professional Education :</b>			
(a) (i) Upgrading at 27 lakhs, conversions at 77 lakhs and creation at 102.0 lakhs per college including the associated hospitals and training fields—			
24 colleges (9+8+7) during the first five years.	15,73,00,000	13,38,00,000	29,11,00,000
19 colleges (7+3+9) during the second five years.			
(ii) Accommodation for personnel under training—	1,08,00,000	85,50,000	1,93,50,000
(b) Dental Education .. ..	60,00,000	75,00,000	1,35,00,000
(c) Pharmaceutical Education ..	6,25,000	6,25,000	12,50,000
(d) Public Health Engineering ..	6,00,000	4,00,000	10,00,000
(e) Nursing .. ..	4,20,00,000	4,20,00,000	8,40,00,000
(f) Improvements to Associated hospitals for training of students during internship ..	48,00,000	38,00,000	86,00,000
(g) Medical Research at Rs. 1 lakh per college .. ..	24,00,000	19,00,000	43,00,000
(h) Hospital Social workers ..	..	..	..
Expenditure on preliminary surveys in four districts on the basis of cost for the Singur survey (Rs. 16,000 for a population of 62,000) .. ..	22,00,000	..	22,00,000
<b>Water Supply—</b>			
(a) Rural .. ..	10,00,00,000	10,00,00,000	20,00,00,000
(b) Urban .. ..	10,00,00,000	10,00,00,000	20,00,00,000
Drainage @ Rs. 6 crores per year	30,00,00,000	30,00,00,000	60,00,00,000
Medical Research (General provision, Provinces) .. ..	20,00,000	20,00,000	40,00,000
<b>TOTAL NON-RECURRING EXPENDITURE .. ..</b>	<b>1,53,74,96,800</b>	<b>1,88,69,82,250</b>	<b>3,42,44,79,050</b>

Estimating the expenditure, recurring and non-recurring, in respect of the Centre, as 6 p.c. in each case of the expenditure for the eleven Provinces together, the figures are as shown below :—

Centre .. ..	9,22,49,808	11,32,18,935	20,54,68,743
British India as a whole ..	1,62,97,46,808	2,00,02,01,185	3,62,99,47,793

ESTIMATES OF COST—*contd.*

	RECURRING.		
	First five years. Rs.	Second five years. Rs.	First ten years. Rs.
Three-million unit scheme	91,91,46,234	2,10,12,29,620	3,02,03,75,854
Central Directorate :—			
(a) Officers .. ..	37,00,000	45,50,000	82,50,000
(b) Establishment and contingencies .. ..	8,00,000	10,00,000	18,00,000
(c) Travelling allowance .. ..	6,25,000	6,25,000	12,50,000
Provincial Directorate—			
(a) Officers .. ..	2,93,81,550	2,95,46,550	5,89,28,100
(b) Establishment and contingencies .. ..	44,00,000	50,60,000	94,60,000
(c) Travelling allowance .. ..	46,75,000	46,75,000	93,50,000
Malaria Organisation .. ..	2,52,07,610	3,85,01,887	6,37,09,497
Tuberculosis .. ..	5,87,71,600	9,94,04,692	15,81,76,292
Mental Diseases .. ..	4,86,59,110	9,63,37,810	14,49,96,920
Venereal Diseases .. ..	3,16,54,110	4,70,17,292	7,86,71,402
Leprosy .. ..	2,86,20,032	6,56,84,356	9,43,04,388
School Health .. ..	18,95,630	23,23,827	42,19,457
Nutrition .. ..	34,37,126	42,88,185	77,25,311
Professional Education :			
(a) Upgrading at 8.25 lakhs, conversion at 17.25 lakhs and creation at 17.25 lakhs per college—			
24 colleges (9+8+7) during the first five years.			
19 colleges (7+3+9) during the second five years ..	16,65,00,000	13,23,75,000	29,88,75,000
(b) Dental Education .. ..	75,00,000	75,00,000	1,50,00,000
(c) Pharmaceutical Education .. ..	23,00,000	23,00,000	46,00,000
(d) Public Health Engineering .. ..	7,50,000	5,00,000	12,50,000
(e) Provincial Sanitary Boards at Rs. 5,000 per board per year (one board for each province) .. ..	2,75,000	2,75,000	5,50,000
(f) Nursing .. ..	10,38,50,000	10,38,50,000	20,77,00,000
(g) Health Assistants .. ..	31,68,000	31,68,000	63,36,000
(h) Hospital social workers .. ..	5,78,420	..	5,78,420
(i) Foreign Scholarships .. ..	15,00,000	15,00,000	30,00,000
(j) Improvements to associated hospitals for the training of interns at Rs. 10,000 per hospital per year .. ..	24,00,000	19,00,000	43,00,000
(k) Postgraduate medical education at Rs. 50,000 per centre per year .. ..	12,50,000	12,50,000	25,00,000
(l) Medical Research in colleges at Rs. 0.25 lakh per year per college .. ..	30,00,000	23,75,000	53,75,000
(m) Scholarships at Rs. 1,000 per year per student for 50 p.o. of the total number of admissions .. ..	1,34,40,000	4,98,00,000	6,32,40,000
(n) Maintenance charges on total capital expenditure on professional education schemes .. ..	1,34,71,500	4,55,93,250	5,90,64,750
Water and Drainage Boards Investigation Units, etc. at Rs. 2.6 lakhs per year .. ..	13,00,066	13,00,000	26,00,000

RECURRING—*contd.*

	First five years. Rs.	Second five years. Rs.	First ten years. Rs.
Maintenance charges @ 3% per year on capital works in connection with Water Supply and Drainage Schemes ..	3,00,00,000	10,50,00,000	13,50,00,000
Health Education at Rs. 3 lakhs per year .. ..	15,00,000	15,00,000	30,00,000
Special Provision for Industrial Health Services .. ..	75,00,000	1,00,00,000	1,75,00,000
Medical Research (general provision, Provinces) .. ..	50,00,000	50,00,000	1,00,00,000
Maintenance charges on capital works erected in connection with Medical Research ..	1,20,000	4,20,000	5,40,000
Leave reserve at 15 p.c. per year for women and 10 p.c. for men personnel—			
Women .. .. .	3,55,38,820	7,59,26,782	11,14,65,602
Men .. .. .	4,27,15,714	7,48,26,896	11,75,42,610
Total .. .. .	1,60,46,30,456	3,12,66,04,147	4,73,12,34,603
On the basis of 6 per cent. of Provincial expenditure, Centre ..	9,62,77,827	18,75,96,249	28,38,74,076
Total for British India ..	1,70,09,08,283	3,31,42,00,396	5,01,51,08,679



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## APPENDIX 55.

## DETAILS OF THE THREE-MILLION UNIT AND OTHER SCHEMES.

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*Non-Recurring.*

	First five years. Rs.	First ten years- Rs.
I.—Primary units—		
(a) Office of the primary unit .. .. .	33,91,60,000	67,84,93,750
(b) Housing for the primary unit staff .. .. .		
(c) Primary unit dispensary, building and equip- ment.		
II.—30-bed hospital—		
(a) building, equipment, and .. .. .	5,62,67,000	27,71,07,500
(b) accommodation for staff .. .. .		
III.—Secondary unit—		
Office, housing for staff including mobile dental clinics organisations .. .. .	3,78,00,000	7,41,95,000
IV.—200-bed hospital—		
Building, equipment and accommodation for staff..	30,70,62,000	31,75,74,000
500-bed hospital .. .. .	..	46,42,60,000
<hr/>		
Ambulances .. .	74,11,79,000	1 81,16,30,250
	1,05,04,000	5,17,40,000
<hr/>		
	75 16,83,000	1,86,33,70, 25



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**PRIMARY UNIT.**  
**(Non-Recurring).**

		Rs.	Rs.
<b>I.—</b>			
(a) Office for each primary unit ..		15,000	
(b) Housing for the primary unit staff ..		1,38,750	
(c) Dispensary building and equipment ..		20,000	1,73,750
<b>4. For all the provinces,</b>			
1st year 1080 × 1,73,750 .. .. =		18,76,50,000	
2nd year .. .. ..		..	
3rd year .. .. ..		..	
4th year 376 × 1,73,750 .. .. =		6,53,30,000	
5th year 496 × 1,73,750 .. .. =		8,61,80,000	33,91,60,000
6th year 341 × 1,73,750 .. .. =		5,92,48,750	
7th year 396 × 1,73,750 .. .. =		6,88,05,000	
8th year 382 × 1,73,750 .. .. =		6,63,72,500	
9th year 414 × 1,73,750 .. .. =		7,19,32,500	
10th year 420 × 1,73,750 .. .. =		7,29,75,000	67,84,93,750

**II. 30-bed hospital—**

(a) Building and equipment .. .. =	55,000	
(b) Accommodation for staff .. .. =	84,250	1,39,25

**3. For all the provinces—**

1st year 216 × 1,39,250 .. .. =	3,00,78,000	
2nd year .. .. ..	..	
3rd year .. .. ..	..	
4th year 188 × 1,39,250 .. .. =	2,61,79,000	
5th year .. .. ..	..	5,62,57,000
6th year 235 × 1,39,250 .. .. =	3,27,23,750	
7th year 282 × 1,39,250 .. .. =	3,92,68,500	
8th year 274 × 1,39,250 .. .. =	3,81,54,500	
9th year 367 × 1,39,250 .. .. =	5,11,04,750	
10th year 428 × 1,39,250 .. .. =	5,95,99,000	27,71,07,600

**C.—Ambulances—**

2 motor—each 12,000 } ..	26,000	
1 animal driven 2,000 .. }		
1st year 216 × 26,000 .. .. =	56,16,000	
2nd year .. .. ..	..	
3rd year .. .. ..	..	
4th year 188 × 26,000 .. .. =	48,88,000	
5th year .. .. ..	..	1,05,84,000
6th year 235 × 26,000 .. .. =	61,10,000	
7th year 282 × 26,000 .. .. =	73,32,000	
8th year 274 × 26,000 .. .. =	71,24,000	
9th year 367 × 26,000 .. .. =	95,42,000	
10th year 428 × 26,000 .. .. =	1,11,28,000	5,17,40,000



**SECONDARY UNIT.**  
(Non-Recurring.)

		Rs.	Rs.
III.—(a) Office for each Secondary unit ..	..	..	30,000
(b) Housing for the staff of the Secondary unit ..	..	..	1,45,000
			<u>1,75,000</u>
2. For all the Provinces—			
1st year $216 \times 1,75,000$ .. .. =	3,78,00,000		
2nd year .. .. ..	..		
3rd year .. .. ..	..		
4th year .. .. ..	..		
5th year .. .. ..	..	3,78,00,000	
6th year .. .. ..	..		
Dental Acco. $216 \times 16,000$ .. .. =	34,56,000		
7th year $66 \times 1,75,000$ .. .. =	1,15,50,000		
Dental $66 \times 16,000$ .. .. =	10,56,000		
8th year $6 \times 1,75,000$ .. .. =	10,50,000		
Dental $6 \times 16,000$ .. .. =	96,000		
9th year .. .. ..	..		
Dental .. .. ..	..	63,90,000	
10th year $67 \times 1,75,000$ .. .. =	1,17,25,000		
Dental $67 \times 16,000$ .. .. =	10,72,000	6,78,05,000	
		<u>7,41,95,000</u>	
IV.—200-bed hospital—			
(a) Building .. .. 7,00,000			
Equipment .. .. 1,00,000			
(b) Accommodation for the staff .. .. 6,25,750	14,25,750		
4. For all the Provinces—			
1st to 5th year $216 \times 14,25,750$ .. .. =	30,79,62,000	30,79,62,000	
6th year .. .. ..	..		
Dental staff acco. $216 \times 44,500$ .. .. =	96,12,000		
7th year .. .. ..	..		
Dental .. .. ..	..		
8th year .. .. ..	..		
Dental .. .. ..	..		
9th year .. .. ..	..		
Dental .. .. ..	..		
10th year .. .. ..	..		
Dental .. .. ..	..	31,75,74,000	

No new 500 bed hospital is ever created. They are to be conversions from 200-bed hospitals, but as soon as a certain number of 200-bed hospitals is converted into those with 500-beds an equal number of 200-bed hospitals is brought into being.

Building .. .. .	Rs. 17,50,000	
Equipment .. .. .	2,50,000	
Accommodation for staff .. .. .	12,70,000	
	<u>32,70,000</u>	
Non-recurring cost of the 500-bed hospital.		1st ten years.
1st to 6th year .. .. .	Nil	
7th year $66 \times 32,70,000$ .. .. .	21,58,20,000	
Dental staff acco. $66 \times 70,000$ .. .. .	46,20,000	
8th year $6 \times 32,70,000$ .. .. .	1,90,20,000	
Dental staff acco. $6 \times 70,000$ .. .. .	4,20,000	
9th year .. .. .	Nil	
10th year—		
$67 \times 32,70,000$ .. .. .	21,90,90,000	
Dental staff acco. $67 \times 70,000$ .. .. .	46,90,000	46,42,60,000

## 3-MILLION UNIT.

## Primary Unit.

I. (a) Office for the primary unit (non-recurring) .. .. Rs. 15,000

(b) Housing for the primary unit staff (non-recurring).

Primary Unit (40,000).	No.	Floor space of housing for one person.	Total.	Total cost of accommodation for one Unit.
Medical Officer @ Rs. 250—25—500 .. ..	2	2,000	4,000	Rs.
Public Health Nurse @ Rs. 100—5—120—10—200 .. ..	4	1,500	6,000	
Nurse @ Rs. 75—5—125 ..	1	1,500	1,500	22,500 sq. ft. @ Rs. 5 per sq. ft.
Midwives @ Rs. 50—5—100 ..	4	1,000	4,000	
Trained dais @ Rs. 25—14—40—2—50 .. ..	4	1,000	4,000	1,12,500
Sanitary inspector @ Rs. 100—5—150 .. ..	2	1,500	3,000	
Health assistant @ Rs. 60—5—100. .. ..	2	1,000	2,000	8,750 Sq. ft. @ Rs. 3 per sq. ft.
Clerks @ Rs. 75—5—150 ..	2	1,000	2,000	
Fitter mistry @ Rs. 40—2—60 .. ..	1	500	500	
Inferior servants— 1 @ Rs. 40—2—60 .. ..	15	250	3,750	
14 @ Rs. 25—2—55 .. ..	1	500	500	26,250
Pharmacist @ Rs. 40—2—60 .. ..				1,38,750
(c) Dispensary at the primary unit— (non-recurring). Building equipment and lands .. ..				20,000

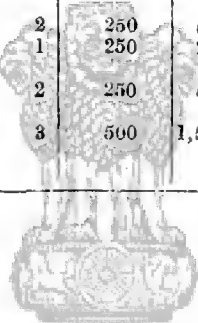
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## 30-BED HOSPITAL.

						Rs.
II. (a)	Building ..	..	..	..	..	45,000
	Equipment ..	..	..	..	..	10,000
						<u>55,000</u>

(b) Accommodation for Staff. — Cost for housing the staff of 30-bed hospital.

	No.	Floor area per head sq. ft.	Total sq. ft.	Rate Rs. per sq. ft.	Total cost.
(1) Medical Officer @ Rs. 250— 25—500 .. .. .	1	2,000	2,000	14,000 sq. ft. @ Rs. 5 per sq. ft.	Rs. 70,000
(2) Nurse 1 @ Rs. 100—5— 175 and 7 @ Rs. 75—5— 125 .. .. .	8	1,500	12,000		
(3) Health assistant @ Rs. 60— 5—100 .. .. .	1	1,000	1,000		
(4) Pharmacist @ Rs. 40—2— 60 .. .. .	1	1,000	1,000	4,750 sq. ft. @ Rs. 3 sq. ft.	14,250
(5) Ward attendants (1 male, 1 female) @ Rs. 30—2— 50 .. .. .	2	250	500		
(6) Cook @ Rs. 30—2—50 .. 1 .. .. .	1	250	250		
(7) Sweepers (1 male, 1 fe. male) @ Rs. 25—1—35 .. 2 .. .. .	2	250	500		
(8) Ambulance drivers @ Rs. 50 .. .. .	3	500	1,500		
				Total ..	<u>84,250</u>



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## SECONDARY UNIT.

## III. Non-recurring.

- (a) Office for the Secondary unit .. .. . Rs. 30,000  
 (b) Housing for the Secondary unit staff.

	No.	Floor rate of area sq. ft.	Total area sq. ft.	Rate of Cost.	Total Cost Rs.
Administrative M. O. @ Rs. 1,000—50—1,250	1	3,000	3,000	Rs. 5	15,000
Deputy A. M. O. @ Rs. 500—30—800 ..	1	2,500	2,500	„	12,500
Assistant A.M.O. @ Rs. 400—30—700 ..	1	2,500	5,000	„	25,000
Assistant P. H. Engineer @ Rs. 400—30—700 ..	1				
Senior Sanitary Inspectors @ Rs. 150—10—250 ..	2	1,750	3,500	„	35,000
Senior P. H. Nurses @ Rs. 150—10—250 ..	2	1,750	3,500		
Head Clerk @ Rs. 200—10—300 ..	1	1,750	3,500	„	17,500
Statistical Clerk @ Rs. 200—10—300 ..	1				
Stenographers @ Rs. 100—5—200 ..	3	1,500	4,500	„	22,500
Clerk (1st Division) @ Rs. 150—10—250 ..	1	1,500	1,500	„	7,500
Clerks (2nd Division) Rs. 75—5—150 ..	2	1,000	2,000	Rs. 3	6,000
Inferior servants @ Rs. 25—5—55 ..	5	250	1,250	„	3,750
				Total ..	1,44,750
				or roughly Rs. 1,45,000 per Secondary Unit.	
<i>In the second five years only—</i>		Total		Cost Rs.	
Dentist at Rs. 250—25—500	1	2,000	2,000	10,000	
Dental Hygienists @ Rs. 80—5—130 ..	2	1,000	2,000	6,000	
				Rs. 16,000	



## IV. Non-recurring.

## 200-BED HOSPITAL.

(a)—Building .. ..	7,00,000
Equipment .. ..	1,00,000
	<u>8,00,000</u>

*Accommodation for the staff of 200-bed hospital.*

(b)—

Personnel.	Number.	Floor area for each sq. ft.	Total floor area sq. ft.	Rate of charge per sq. ft.	Total charge Rs.
Superintendent (Rs. 500—30—800)	1	2,500	2,500		
Medical Officer in charge (Rs. 400—30—700)	3	2,500	7,500		
House Staff (Rs. 250—25—500)	6	2,000	12,000	Rs. 5/- per sq. ft.	5,05,000
Assistant M. Os. in Charge of Laboratory (Rs. 250—25—500)	2	2,000	4,000		
Nurses .. ..	50	1,500	75,000		
Senior Pharmacist (Rs. 60—3—90)	1	625	625		
Laboratory Technicians (Rs. 60—5—100)	3	625	1,875		
Caretaker (animals) (Rs. 40—2—60)	1	500	500		
Laboratory attendants (Rs. 30—2—50)	3	250	750	Rs. 3/- per sq. ft.	54,750
Pharmacists (Rs. 40—2—60)	6	500	3,000		
Ward attendants (Rs. 30—2—50)	16	250	4,000		
Sweepers (Rs. 25—1—35)	8	250	2,000		
Cooks (Rs. 30—2—50)	4	250	1,000		
Malis (Rs. 25—1—35)	1	500	500		
Mistrie (Rs. 40—2—60)	1	1,500	1,500	Rs. 5/- per sq. ft.	15,000
Clerk (1st Division) (Rs. 150—10—250)	1	1,500	1,500		
Stenographer (Rs. 100—5—200)	1	1,000	1,000	Rs. 3/-	4,500
Clerk (2nd Division) (Rs. 75—5—150)	1	250	250		
Peons (Rs. 25—2—55)	2				

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**200—BED HOSPITAL—contd.**  
**Accommodation for the staff of 200-bed hospital.—contd.**

Personnel.	Number.	Floor area for each sq. ft.	Total floor area sq. ft.	Rate of charge per sq. ft.	Total charge Rs.
Senior M. O. (X-ray) (Rs. 400—30—700) ..	1	2,500	2,500	Rs.5/- per sq. ft.	45,000
Junior M. O. (X-ray) (Rs. 250—25—500) ..	1	2,000	2,000		
Technician (X-ray) (Rs. 150—10—250) ..	1	1,500	1,500		
Nurses 1 (Rs. 100—5—150) and 1 (Rs. 75—5—125)	2	1,500	3,000		
Attendants (Rs. 25—2—55) ..	2	250	500	Rs.3/- per sq. ft.	1,500
				Total ..	6,25,750

**ONLY IN THE SECOND FIVE YEARS.**

**Accommodation for the Dental Organisation attached to each 200-bed hospital.**

Orthodontal Surgeon (Rs. 375—25—750) ..	1	2,500	2,500	Rs.5/- per sq. ft.	32,500
Dentists (Rs. 250—25—500) ..	2	2,000	4,000		
Dental hygienists (Rs. 80—15—130) ..	4	1,000	4,000	Rs.3/- per sq. ft.	12,000
				Total	44,500
					only in the 2nd five years.

*Non-recurring*  
Building & equipment.—

500-BED HOSPITAL.

Building.....	17,50,300
Equipment.....	2,50,000
	<u>20,00,000</u>

*Accommodation for the staff of 500-bed hospital.*

Personnel.	No.	Floor area for each sq. ft.	Total floor area sq. ft.	Rate of charge per sq. ft. (Rs.)	Total charge Rs.
Superintendent (Rs. 600—30—900)	1	2,500	2,500	Rs. 6 per sq. ft.	10,67,500
M. O. in charge (Rs. 400—30—700)	3	2,500	7,500		
House Staff (Rs. 250—25—500)	6	2,000	12,000		
Assistant M. O. in charge of Laboratory (Rs. 250—25—500)	2	2,000	4,000		
Nurses ..	125	1,500	1,87,500	Rs. 3 per sq. ft.	1,01,250
Senior Pharmacist	1	625	625		
Laboratory Technicians	3	625	1,875		
Caretaker (animals)	1	500	500		
Laboratory attendants	3	250	750		
Pharmacists	16	500	8,000		
Ward attendants ..	32	250	8,000		
Sweepers ..	32	250	8,000		
Cooks ..	16	250	4,000		
Malis ..	4	250	1,000		
Mistry ..	1	500	500		
Inferior servant ..	2	250	500		
Clerk (1st Division)	1	1,500	1,500	Rs. 5 per sq. ft.	20,000
Stenographer ..	1	1,500	1,500		
Clerk (2nd Division)	1	1,000	1,000		



## 500-BED HOSPITAL—contd.

## Accommodation for the staff of 500-bed hospital—contd.

Personnel	No.	Floor area for each sq. ft.	Total floor area sq. ft.	Rate of charge per sq. ft. (Rs.)	Total charge. Rs.
Senior M. O. (X-ray) (Rs. 400—30—700)	1	2,500	2,500	Rs. 5 per sq. ft.	77,500
Junior M. O. (X-ray) (Rs. 250—25—500)	2	2,000	4,000		
Technicians (Rs. 150—10—250)	2	1,500	3,000		
Nurses .. ..	4	1,500	6,000		
Attendants (Rs. 25—2—55)	4	250	1,000	Rs. 3 per sq. ft.	3,000
				Total ..	12,69,250 or Rs. 12,70,000

IN THE SECOND FIVE YEARS ONLY

Accommodation for the Dental organisation attached to a 500-bed hospital.

	No.	sq. ft.	Total sq. ft.	Rate per sq. ft.	Total cost (Rs.)
Officer-in-Charge of Dental Section (Rs. 500.30.800)	1	2,500	2,500	Rs. 5 per sq. ft.	55,000
Orthodontal Surgeon (Rs. 375—25—750)	1	2,500	2,500		
Dentists (Rs. 250—25—500)	3	2,000	6,000	Rs. 3 per sq. ft.	15,000
Dental Hygienists (Rs. 50—6—130)	5	1,000	5,000		
			Total ..	Total ..	70,000

## RECURRING.

					First five years.	First ten years.
					Rs.	Rs.
<b>I. Primary Unit.</b>						
(a) Staff salary	..	..	..	..	28,92,66,264	1,05,01,52,805
(b) Dispensary: drugs, and sundries	..	..	..	..	2,45,97,600	8,17,36,700
<b>II. 30-bed hospital.</b>						
(a) Staff salary	..	..	..	..	2,95,80,980	16,53,97,469
(b) Drugs, sundries and diet	..	..	..	..	2,18,40,000	11,64,45,000
(c) Ambulance maintenance	..	..	..	..	1,09,20,000	5,82,22,500
<b>III. Secondary Unit.</b>						
Staff salary	..	..	..	..	8,34,67,152	22,72,96,865
<b>IV. (a) Staff salary---</b>						
200-bed hospital	..	..	..	..	22,01,44,392	49,11,82,593
500-bed hospital	..	..	..	..	..	16,18,43,754
<b>(b) Drugs, sundries and diet</b>						
200-bed hospital	..	..	..	..	10,80,00,000	21,60,00,000
500-bed hospital	..	..	..	..	..	8,72,50,000
<b>V. Administrative Organisation at the District headquarters.</b>					5,81,65,776	12,25,73,736
<b>VI. Preparation of House Lists</b>					28,00,000	60,00,000
<b>Total</b>					<b>84,87,82,164</b>	<b>278,41,01,422</b>
<i>Maintenance charges on capital works in connection with three million unit scheme.</i>						
Primary unit	..	..	..	..	2,44,77,900	9,49,88,525
30-bed hospital	..	..	..	..	43,94,730	2,41,16,707
Secondary unit	..	..	..	..	45,36,000	1,18,24,020
200-bed hospital	..	..	..	..	3,69,55,440	8,43,03,180
500-bed hospital	..	..	..	..	..	2,10,42,000
<b>Total</b>					<b>7,03,64,070</b>	<b>23,62,74,432</b>
<b>Grand Total</b>					<b>91,91,46,234</b>	<b>302,03,75,854</b>

## RECURRING.

**I. Primary unit.****(a) Staff salaries (see for further details pp.267-268)**

					Rs.	Rs.
1st year	..	..	..	..	4,28,24,160	
2nd year	..	..	..	..	4,53,06,000	
3rd year	..	..	..	..	4,77,84,600	
4th year	..	..	..	..	6,51,72,352	
5th year	..	..	..	..	8,81,79,152	<u>28,92,66,264</u>
6th year	..	..	..	..	10,73,63,332	
7th year	..	..	..	..	12,86,81,062	
8th year	..	..	..	..	15,03,49,361	
9th year	..	..	..	..	17,45,74,156	
10th year	..	..	..	..	19,99,18,630	<u>1,05,01,52,805</u>

**(b) Dispensary.**

Recurring cost in respect of drugs, sundries and maintenance of emergency beds.

					Rs.	Rs.
Drugs	..	..	..	..	1,500	
Sundries	..	..	..	..	600	
Emergency beds	..	..	..	..	600	
Two Maternity beds at Rs. 500 per bed	..	..	..	..	1,000	
					<u>3,700</u>	
1st year 1080 × 3,700	..	..	..	..	39,96,000	
2nd year Do.	..	..	..	..	39,96,000	
3rd year Do.	..	..	..	..	39,96,000	
4th year 1456 × 3,700	..	..	..	..	53,87,200	
5th year 1952 × 3,700	..	..	..	..	72,22,400	<u>2,45,97,600</u>
6th year 2293 × 3,700	..	..	..	..	84,84,100	
7th year 2639 × 3,700	..	..	..	..	99,49,300	
8th year 3071 × 3,700	..	..	..	..	1,13,62,700	
9th year 3485 × 3,700	..	..	..	..	1,28,94,500	
10th year 3905 × 3,700	..	..	..	..	1,44,48,500	<u>8,17,36,700</u>

## RECURRING.

## II. 30-bed hospital.

(a) Staff salary. (see for further details pp. 269-270).

	Rs.	Rs.
1st year .. .. .	40,00,538	
2nd year .. .. .	42,40,941	
3rd year .. .. .	44,81,568	
4th year .. .. .	82,04,140	
5th year .. .. .	86,53,792	2,85,80,289
6th year .. .. .	1,35,34,907	
7th year .. .. .	1,94,73,328	
8th year .. .. .	2,55,77,710	
9th year .. .. .	3,37,78,409	
10th year .. .. .	4,34,52,135	16,53,97,489

(b) Drugs, sundries and diet.

Drugs .. .. .	4,500	
Sundries .. .. .	1,500	
Diet .. .. .	9,000	
	15,000	
1st year 216 × 15,000 .. .. .	32,40,000	
2nd year 216 × 15,000 .. .. .	32,40,000	
3rd year 216 × 15,000 .. .. .	32,40,000	
4th year 404 × 15,000 .. .. .	60,60,000	
5th year 404 × 15,000 .. .. .	60,60,000	2,18,40,000
6th year 639 × 15,000 .. .. .	95,85,000	
7th year 921 × 15,000 .. .. .	1,38,15,000	
8th year 1195 × 15,000 .. .. .	1,79,25,000	
9th year 1562 × 15,000 .. .. .	2,34,30,000	
10th year 1990 × 15,000 .. .. .	2,98,50,000	11,64,45,000

(c) Ambulance maintenance.

For 2 motors ..	6,000	
For 1 animal drawn ..	1,500	7,500 per year
1st year 216 × 7,500 .. .. .	16,20,000	
2nd year 216 × 7,500 .. .. .	16,20,000	
3rd year 216 × 7,500 .. .. .	16,20,000	
4th year 404 × 7,500 .. .. .	30,30,000	
5th year 404 × 7,500 .. .. .	30,30,000	1,09,20,000
6th year 639 × 7,500 .. .. .	47,92,500	
7th year 921 × 7,500 .. .. .	69,07,500	
8th year 1195 × 7,500 .. .. .	89,62,500	
9th year 1562 × 7,500 .. .. .	1,17,15,000	
10th year 1990 × 7,500 .. .. .	1,49,25,000	5,82,22,500

## III. Secondary Unit.

Staff salary (see for further details pp. 271-272).

1st year .. .. .	1,51,96,896	
2nd year .. .. .	1,59,33,456	
3rd year .. .. .	1,66,95,504	
4th year .. .. .	1,74,45,024	
5th year .. .. .	1,81,96,272	8,34,67,152
6th year .. .. .	2,13,06,024	
7th year .. .. .	2,74,01,406	
8th year .. .. .	2,88,69,750	
9th year .. .. .	2,98,80,576	
10th year .. .. .	3,63,71,957	22,72,96,865

## RECURRING.

## IV. (a) 200-bed hospital.

Staff salary (see for further details pp. 274-276).

	Rs.	Rs.
1st year .. .. .	3,91,81,960	
2nd year .. .. .	4,16,09,376	
3rd year .. .. .	4,40,26,632	
4th year .. .. .	4,64,48,424	
5th year .. .. .	4,88,70,000	<u>22,01,44,392</u>
6th year .. .. .	5,55,71,400	
7th year .. .. .	5,24,76,660	
8th year .. .. .	5,45,20,314	
9th year .. .. .	5,71,62,126	
10th year .. .. .	5,13,07,701	<u>49,11,82,593</u>

## 500-bed hospital.

Staff salary (see for further details pp. 277-280).

7th year .. .. .	2,83,45,482	
8th year .. .. .	3,24,59,484	
9th year .. .. .	3,40,54,044	
10th year .. .. .	6,69,84,744	<u>16,18,43,754</u>

(b) Drugs, Sundries and Diet.  
for the 200-bed hospital.

Drugs and sundries	40,000		
Diet .. .. .	60,000	<u>1,00,000</u>	
1st year $216 \times 1,00,000$	.. .. .	2,16,00,000	
2nd year $216 \times 1,00,000$	.. .. .	2,16,00,000	
3rd year $216 \times 1,00,000$	.. .. .	2,16,00,000	
4th year $216 \times 1,00,000$	.. .. .	2,16,00,000	
5th year $216 \times 1,00,000$	.. .. .	2,16,00,000	<u>10,80,00,000</u>
6th year $216 \times 1,00,000$	.. .. .	2,16,00,000	
7th year $216 \times 1,00,000$	.. .. .	2,16,00,000	
8th year $216 \times 1,00,000$	.. .. .	2,16,00,000	
9th year $216 \times 1,00,000$	.. .. .	2,16,00,000	
10th year $216 \times 1,00,000$	.. .. .	2,16,00,000	<u>21,60,00,000</u>

## For 500-bed hospital

Drugs and sundries	1,00,000		
Diet .. .. .	1,50,000	<u>2,50,000</u>	
7th year $66 \times 2,50,000$	.. .. .	1,65,00,000	
8th year $72 \times 2,50,000$	.. .. .	1,80,00,000	
9th year $72 \times 2,50,000$	.. .. .	1,80,00,000	
10th year $139 \times 2,50,000$	.. .. .	3,47,50,000	<u>8,72,50,000</u>

**V. Recurring cost in respect of the Administration organisation at the District Headquarters.**

(see for further details p. 281).

**1st five years.**

						Rs.
One such organisation	..	..	..	..	..	2,69,286
216 „ „	..	..	..	..	..	6,81,65,776

**2nd five years.**

One such organisation	..	..	..	..	..	2,98,185
216 „ „	..	..	..	..	..	6,44,07,960

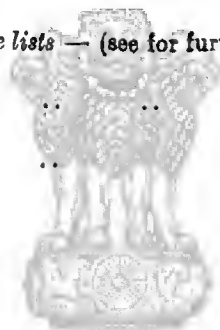
**1st ten years.**

For 216 District Headquarters Organisation	..	..	..	..	..	12,25,73,736
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**VI. Preparation of House lists — (see for further details pp. 282-285).**

1st five years .. .. Rs. 28 lakhs.

1st ten years .. ..



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*Total expenses in respect of salaries of staff of all Primary Units during the first ten year period.*

Year.	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
1st	(1,080 × 39,652) 4,28,24,160	(1,080 × 41,950) 4,53,06,000	(1,080 × 44,245) 4,77,84,800	(1,080 × 46,540) 5,02,83,200	(1,080 × 48,832) 5,27,38,560	(1,080 × 52,221) 5,63,98,680	(1,080 × 54,642) 5,92,20,360	(1,080 × 57,461) 6,20,57,880	(1,080 × 60,080) 6,48,86,400	(1,080 × 62,568) 6,75,62,640
2nd	..	..	..	..	..	..	..	..	..	..
3rd	..	..	..	..	..	..	..	..	..	..
4th	..	..	..	(376 × 39,652) 1,49,09,151	(376 × 41,950) 1,57,73,200	(376 × 44,245) 1,66,36,120	(376 × 46,540) 1,74,99,040	(376 × 48,832) 1,83,60,832	(376 × 52,221) 1,90,35,086	(376 × 54,642) 2,06,20,592
5th	..	..	..	..	(496 × 39,652) 1,96,67,392	(496 × 41,950) 2,08,07,200	(496 × 44,245) 2,19,45,520	(496 × 46,540) 2,30,83,940	(496 × 48,832) 2,42,20,672	(496 × 52,221) 2,59,01,616
6th	..	..	..	..	..	(341 × 39,652) 13,52,21,332	(341 × 41,950) 1,43,01,950	(341 × 44,245) 1,50,87,545	(341 × 46,540) 1,58,70,140	(341 × 48,832) 1,64,81,212
7th	..	..	..	..	..	..	(396 × 39,652) 1,57,02,192	(396 × 41,950) 1,66,12,300	(396 × 44,245) 1,75,21,020	(396 × 46,540) 1,84,39,840
8th	..	..	..	..	..	..	..	(382 × 39,652) 1,51,47,064	(382 × 41,950) 1,60,24,900	(382 × 44,245) 1,69,01,590
9th	..	..	..	..	..	..	..	..	(414 × 39,652) 1,64,15,928	(414 × 41,950) 1,73,67,800
10th	..	..	..	..	..	..	..	..	..	(420 × 39,652) 1,66,53,840
Total for the first ten years	4,28,24,160	4,53,06,000	4,77,84,800	6,51,72,352	8,81,79,152	10,72,63,332	12,86,81,982	15,03,49,361	17,45,74,166	19,99,18,630

Five years—Rs. 28,92,64,264

Ten years—Rs. 1,08,01,48,804

**30-BED HOSPITAL**  
**SALARY OF STAFF.**  
*Recurring—further details.*

## II (a).

	Number.	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
		Ra.	Ra.	Ra.	Ra.	Ra.	Ra.	Ra.	Ra.	Ra.	Ra.
Medical Officer @ Rs. 250—25—500 .. ..	1	3,000	3,300	3,600	3,900	4,200	4,500	4,800	5,100	5,400	5,700
Staff Nurses @ Rs. 100—5—175 .. ..	1	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740
Nurses @ Rs. 75—5—125 .. ..	7	6,300	6,720	7,140	7,560	7,980	8,400	8,820	9,240	9,660	10,080
Health Assistant @ Rs. 60—5—100 .. ..	1	720	780	840	900	960	1,020	1,080	1,140	1,200	1,260
Pharmacist @ Rs. 40—2—60 .. ..	1	480	504	528	552	576	600	624	648	672	696
War Attendants @ Rs. 30—2—50 .. ..	2	720	768	816	864	912	960	1,008	1,056	1,104	1,152
Cook @ Rs. 30—2—50 .. ..	1	360	384	408	432	456	480	504	528	552	576
Sweepers @ Rs. 25—1—35 .. ..	2	600	624	648	672	696	720	744	768	792	816
Contingencies .. ..		3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
Leave salary & pension contributions .. ..		2,141	2,294	2,448	2,602	2,755	3,273	3,445	3,618	3,791	3,963
Total .. ..		18,521	19,634	20,748	21,862	22,975	24,453	25,585	26,718	27,851	28,983

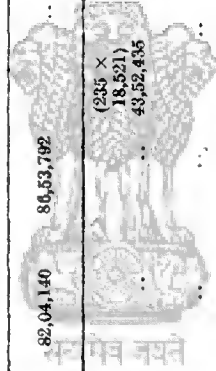
## II b.—Drugs, sundries and diet.—

Drugs .. ..	4,500
Sundries .. ..	1,500
Diet (at Rs. 300 per bed per year) .. ..	9,000
Total .. ..	15,000 per year.



*Total cost in respect of salaries of staff of all the 30-bed hospitals for the first ten years.*

	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
	Rs. (216 × 18,521)	Rs. (216 × 19,634)	Rs. (216 × 20,748)	Rs. (216 × 21,862)	Rs. (216 × 22,975)	Rs. (216 × 24,453)	Rs. (216 × 25,585)	Rs. (216 × 26,718)	Rs. (216 × 27,851)	Rs. (216 × 28,983)
1st year	40,00,536	42,40,944	44,81,568	47,22,192	49,62,600	52,81,848	55,26,360	57,71,088	60,15,816	62,60,328
2nd year	..	..	..	..	..	..	..	..	..	..
3rd year	..	..	..	..	..	..	..	..	..	..
4th year	..	..	..	..	..	..	..	..	..	..
5th year	..	..	..	..	..	..	..	..	..	..
Total for the first five years.	40,00,536	42,40,944	44,81,568	47,22,192	49,62,600	52,81,848	55,26,360	57,71,088	60,15,816	62,60,328
6th year	..	..	..	..	..	..	..	..	..	..
7th year	..	..	..	..	..	..	..	..	..	..
8th year	..	..	..	..	..	..	..	..	..	..
9th year	..	..	..	..	..	..	..	..	..	..
10th year	..	..	..	..	..	..	..	..	..	..
Total for the first ten years.	40,00,536	42,40,944	44,81,568	47,22,192	49,62,600	52,81,848	55,26,360	57,71,088	60,15,816	62,60,328



Total for the second five years

1,35,34,907

1,94,73,328

2,55,77,710

3,37,18,409

4,31,51,135

**SECONDARY UNIT STAFF.**  
(*Recurring—further details.*)

Number.	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
Administrative M. O. @ Rs. 1,800—50—1,200 Deputy A.M.O. @ Rs. 500—30— 800 .. .. .	12,000	12,600	13,200	13,800	14,400	14,400	14,400	14,400	14,400	14,400
Assistant A. M. O. (Maternity & C. W.) @ Rs. 400—30—700 .. .. .	6,000	6,360	6,720	7,080	7,440	7,800	8,160	8,520	8,880	9,340
Assistant Public Health Engineer @ Rs. 400—30—700 .. .. .	4,800	5,160	5,520	5,880	6,240	6,600	6,960	7,320	7,680	8,040
Senior Sanitary Inspectors @ Rs. 150—0—250 .. .. .	4,800	5,160	5,520	5,880	6,240	6,600	6,960	7,320	7,680	8,040
Senior Public Health Nurses @ Rs. 150—10—250 .. .. .	3,600	3,840	4,080	4,320	4,560	4,800	5,050	5,280	5,520	5,760
Head clerk @ Rs. 200—10—30 .. .. .	3,600	3,840	4,080	4,320	4,560	4,800	5,040	5,280	5,520	5,760
Statistical clerk @ Rs. 200—10—300 .. .. .	2,400	2,520	2,640	2,760	2,880	3,000	3,120	3,240	3,360	3,480
Stenographers @ Rs. 100—5—200 .. .. .	2,400	2,520	2,640	2,760	2,880	3,000	3,120	3,240	3,360	3,480
Clerk (1st Division) @ Rs. 150—10—250 .. .. .	3,600	3,780	3,960	4,140	4,320	4,500	4,680	4,860	5,040	5,220
Clerk (2nd Division) @ Rs. 75—5—150 .. .. .	1,800	1,920	2,040	2,160	2,280	2,400	2,520	2,640	2,760	2,880
Inferior servants @ Rs. 25—2—55 .. .. .	1,800	1,920	2,040	2,160	2,280	2,400	2,520	2,640	2,760	2,880
Allowances .. .. .	1,500	1,620	1,740	1,860	1,980	2,100	2,220	2,340	2,460	2,580
Contingencies .. .. .	8,400	8,400	8,400	8,400	8,400	8,400	8,400	8,400	8,400	8,400
Pension & Leave salary charges .. .. .	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
	10,656	11,126	11,714	12,244	12,782	13,752	14,217	14,681	15,144	15,631
<b>Total .. .. .</b>	<b>Rs. 70,356</b>	<b>73,766</b>	<b>77,294</b>	<b>80,764</b>	<b>84,242</b>	<b>87,652</b>	<b>90,367</b>	<b>93,161</b>	<b>95,964</b>	<b>98,891</b>

*Mobile Dental Organisation (One for each Secondary Centre in the Second five years).*

	Number.	1st year.	2nd year.	3rd year.	4th year.	5th year.
Dentist @ Rs. 250-25-500 ..	1	Rs. 3,000	Rs. 3,300	Rs. 3,600	Rs. 3,900	Rs. 4,200
Dental Hygienists @ Rs. 80-5-130 ..	2	1,920	2,040	2,160	2,280	2,400
Attendant @ Rs. 30-2-50 ..	1	360	384	408	432	456
Pension & leave salary ..		1,007	1,092	1,176	1,260	1,345
Cost of drugs and dental materials ..		1,200	1,200	1,200	1,200	1,200
Maintenance, transportation and depreciation charges ..	3,600	3,600	3,600	3,600	3,600	3,600
Total ..		11,087	11,616	12,144	12,672	13,201

*Salaries of staffs of all secondary units.*

	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
1st to 6th year of the scheme.	Rs. (216 × 70,356) 1,51,93,896	Rs. (216 × 73,766) 1,59,33,456	Rs. (216 × 77,294) 1,66,95,504	Rs. (216 × 80,764) 1,74,45,024	Rs. (216 × 84,242) 1,81,96,272	Rs. (216 × 87,652) 1,89,11,232	Rs. (216 × 90,357) 1,95,17,112	Rs. (216 × 93,161) 2,01,22,776	Rs. (216 × 95,964) 2,07,28,224	Rs. (216 × 98,891) 2,13,60,456
7th year ..							Rs. (66 × 70,356) 4,63,496	Rs. (66 × 73,766) 4,86,556	Rs. (66 × 77,294) 5,10,404	Rs. (66 × 80,764) 5,30,424
8th year ..								Rs. (6 × 70,356) 4,22,136	Rs. (6 × 73,766) 4,42,496	Rs. (6 × 77,294) 4,63,764
9th year ..									Rs. (67 × 70,356) 4,71,352	
10th year ..										Rs. (67 × 70,356) 4,71,352
Total ..	1,51,96,896	1,59,33,456	1,66,95,504	1,74,45,024	1,81,96,272	1,89,11,232	2,41,60,508	2,54,13,468	2,62,72,224	3,18,68,496
Total recurring expenditure on Mobile Dental Organisations (from the accompanying sheets).						23,34,792	32,40,798	34,58,282	36,08,352	45,03,481
1st five years ..	1,51,96,896	1,59,33,456	1,66,95,504	1,74,45,024	1,81,96,272	2,13,06,024	2,74,01,405	2,98,69,750	2,98,80,576	3,63,71,957
Second five years ..							Rs. 14,38,29,713.			

*Expenditure of the Mobile Dental Organisations attached to secondary units (one to each secondary unit in the second five years only).*

	6th year.	7th year.	8th year.	9th year.	10th year.
6th year ..	(216 × 11,087) 23,94,792	(216 × 11,616) 25,09,056	(216 × 12,144) 26,23,104	(216 × 12,672) 27,37,152	(216 × 13,201) 28,51,416
7th year ..	..	(66 × 11,087) 7,31,742	(66 × 11,616) 7,66,656	(66 × 12,144) 8,01,604	(66 × 12,672) 8,36,352
8th year ..	..	..	(6 × 11,087) 66,522	(6 × 11,616) 69,696	(6 × 12,144) 72,864
9th year ..	..	..	..	..	(67 × 11,087) 7,42,829
10th year ..	..	..	..	..	..
<b>Total</b> ..	<b>23,94,792</b>	<b>32,40,798</b>	<b>34,56,282</b>	<b>36,08,352</b>	<b>45,03,461</b>
<b>Grand Total ..</b>					<b>1,72,03,685</b>

## 200-BED HOSPITAL :

## SALARY OF STAFF—Further Details.

IV. (c).

	Number	1st year. Rs.	2nd year. Rs.	3rd year. Rs.	4th year. Rs.	5th year. Rs.	6th year. Rs.	7th year. Rs.	8th year. Rs.	9th year. Rs.	10th year. Rs.
Superintendent. @ Rs. 500—30—800 ..	1	6,000	6,350	6,720	7,080	7,440	7,800	8,160	85,20	8,880	9,240
M.O's. in-Charge of Departments of Medicine, Surgery & Midwifery & Gynaecology. @ Rs. 400—30—700 ..	2	9,800	10,320	11,040	11,760	12,480	13,200	13,920	14,640	15,360	16,080
M.O. in-Charge of Laboratory @ Rs. 400—30—700 ..	1	4,800	5,160	5,520	5,880	6,240	6,600	6,960	7,320	7,680	8,040
House Staff. @ Rs. 250—25—500 ..	6	18,000	19,800	21,600	23,400	25,200	27,000	28,800	30,600	32,400	34,200
Assistant M.O. in-Charge of Laboratory. @ Rs. 250—25—500 ..	2	6,000	6,600	7,200	7,800	8,400	9,000	9,600	10,200	10,800	11,400
Part-time Doctors. @ Rs. 100 p.m. ..	3	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600
Matron. @ Rs. 200—10—300 ..	1	2,400	2,520	2,640	2,760	2,880	3,000	3,120	3,240	3,360	3,480
Assistant Matron. @ Rs. 150—5—200 ..	1	1,800	1,860	1,920	1,980	2,040	2,100	2,160	2,220	2,280	2,340
Sister Tutor. @ Rs. 140—5—190 ..	1	1,680	1,740	1,800	1,860	1,920	1,980	2,040	2,100	2,160	2,220
Night Sister. @ Rs. 135—5—185 ..	1	1,620	1,680	1,740	1,800	1,860	1,920	1,980	2,040	2,100	2,160
Theatre Sisters. @ Rs. 125—5—175 ..	2	3,000	3,120	3,240	3,360	3,480	3,600	3,720	3,840	3,960	4,080
Ward Sisters. @ Rs. 115—5—165 ..	4	5,520	5,760	6,000	6,240	6,480	6,720	6,960	7,200	7,440	7,680
Staff Nurses. @ Rs. 100—5—175 ..	19	22,800	23,940	25,080	26,220	27,360	28,500	29,640	30,780	31,920	33,060
Staff Nurses. @ Rs. 75—5—125 ..	17	15,300	16,320	17,340	18,360	19,380	20,400	21,420	22,440	23,460	24,480

Night Staff Nurses.													
House Sister.	2	1,800	1,920	2,040	2,160	2,280	2,400	2,520	2,640	2,760	2,880		
House Sister.	1	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740		
House Keeper.	1	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740		
Senior Pharmacist.	1	720	756	792	828	864	900	936	972	1,008	1,044		
Laboratory Technician.	3	2,160	2,340	2,520	2,700	2,880	3,060	3,240	3,420	3,600	3,780		
Careraker.	1	480	504	528	552	576	600	624	648	672	696		
Laboratory attendants.	3	1,080	1,162	1,224	1,286	1,368	1,440	1,512	1,584	1,656	1,728		
Pharmacist.	6	2,880	3,024	3,168	3,312	3,456	3,600	3,744	3,888	4,032	4,176		
Ward attendants.	16	6,760	6,144	6,528	6,912	7,296	7,680	8,064	8,448	8,832	9,216		
Sweepers.	16	4,800	4,992	5,184	5,376	5,568	5,760	5,952	6,144	6,336	6,528		
Cooks.	8	2,880	13,072	3,264	3,456	3,648	3,840	4,032	4,224	4,416	4,608		
Mali.	4	1,200	1,248	1,296	1,344	1,392	1,440	1,488	1,536	1,584	1,632		
Mistrie.	1	480	504	528	552	576	600	624	648	672	696		
Clerk.	1	1,800	1,920	2,040	2,160	2,280	2,400	2,520	2,640	2,760	2,880		
Stenographer.	1	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740		
Clerk.	1	900	960	1,020	1,080	1,140	1,200	1,260	1,320	1,380	1,440		
Peon.	2	600	648	696	744	792	840	888	936	984	1,032		
Pension & leave salary		23,439	24,997	26,556	28,113	29,671	31,229	32,787	34,345	35,903	37,461		
Charges.		5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000		
contingencies													

## 200-BED HOSPITAL—contd.

	Number 1st year	2nd year	3rd year	4th year	5th year	6th year	7th year	8th year	9th year	10th year
	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
Allowances ..	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
<i>X-ray staff.</i>										
Senior M.O. (x-ray) ..	4,800	5,160	5,520	5,880	6,240	6,600	6,960	7,320	7,680	8,040
@ Rs. 400—30—700 ..										
Assistant M.O. (x-ray) ..	3,000	3,300	3,600	3,900	4,200	4,500	4,800	5,100	5,400	5,700
@ Rs. 250—25—500 ..										
Technician ..	1,800	1,920	2,040	2,160	2,280	2,400	2,520	2,640	2,760	2,880
@ Rs. 150—10—250 ..										
Nurses ..	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740
@ Rs. 100—5—150 ..										
@ Rs. 75—5—125 ..	900	960	1,020	1,080	1,140	1,200	1,260	1,320	1,380	1,440
@ Rs. 50—5—100 ..	600	648	696	744	792	840	888	936	984	1,032
Attendants ..										
@ Rs. 25—2—55 ..										
Pension & leave salary charges ..	2,436	2,647	2,818	3,010	3,201	3,511	3,708	3,905	4,103	4,300
<i>Dental Service.</i>										
Orthodontal Surgeon ..										
@ Rs. 375—25—750 ..	1									
Dentists ..	2									
@ Rs. 250—25—500 ..										
Dental Hygienists ..	4									
@ Rs. 80—5—130 ..										
Pension & leave salary charges ..										
Total ..	1,81,435	1,92,636	2,03,827	2,15,039	2,26,250	2,57,275	2,70,013	2,82,762	2,95,512	3,08,260

## IV. (b).

## Drugs, Sundries &amp; Diet.—

Drugs & sundries ..	Rs.
Diet ..	40,000
Total ..	60,000
1,00,000 per 200-bed hospital.	

**500-BED HOSPITAL.**  
**(SALARY OF STAFF—FURTHER DETAIL)**

**IV. (a)**  
**Recurring.**

Number.	1st year Rs.	2nd year Rs.	3rd year Rs.	4th year Rs.	5th year Rs.	6th year Rs.	7th year Rs.	8th year Rs.	9th year Rs.	10th year Rs.
Superintendent. @ Rs. 600—30—900 ..	1	7,200	7,560	7,920	8,280	8,640	9,000	9,360	9,720	10,080
M.O.s. in-Charge of Departments of Medicine, Surgery & Midwifery and Gynaecology. @ Rs. 400—30—700 ..	2	9,600	10,320	11,040	11,760	12,480	13,200	13,920	14,640	15,360
M.O. in-Charge of Laboratory. @ Rs. 400—30—700 ..	1	4,800	5,160	5,520	5,880	6,240	6,600	6,960	7,320	7,680
House Staff. @ Rs. 250—25—500 ..	6	18,000	19,800	21,600	23,400	25,200	27,000	28,800	30,600	32,400
Assistant M.O. in-Charge of Laboratory. @ Rs. 250—25—500 ..	2	6,000	6,600	7,200	7,800	8,400	9,000	9,600	10,200	10,800
Part-time Doctors. @ Rs. 100 p.m. ..	3	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600
Matron. @ Rs. 200—10—300 ..	1	2,400	2,520	2,640	2,760	2,880	3,000	3,120	3,240	3,360
Assistant Matron. @ Rs. 150—5—200 ..	1	1,800	1,860	1,920	1,980	2,040	2,100	2,160	2,220	2,280
Sister Tutor. @ Rs. 140—5—190 ..	1	1,680	1,740	1,800	1,860	1,920	1,980	2,040	2,100	2,160
Night Sister. @ Rs. 135—5—185 ..	1	1,620	1,680	1,740	1,800	1,860	1,920	1,980	2,040	2,100
Theatre Sister. @ Rs. 125—5—175 ..	3	4,500	4,680	4,860	5,040	5,220	5,400	5,580	5,760	5,940
Night Staff Nurses. @ Rs. 100—5—175 ..	2	2,400	2,520	2,640	2,760	2,880	3,000	3,120	3,240	3,360
Assistant Night Sister. @ Rs. 115—5—165 ..	1	1,380	1,440	1,500	1,560	1,620	1,680	1,740	1,800	1,860
Special Department Nurses. @ Rs. 100—5—175 ..	30	36,000	37,800	39,600	41,400	43,200	45,000	46,800	48,600	50,400
										52,200



500-BED HOSPITAL--cont'd.

Number.	1st year Rs.	2nd year Rs.	3rd year Rs.	4th year Rs.	5th year Rs.	6th year Rs.	7th year Rs.	8th year Rs.	9th year Rs.	10th year Rs.
<b>Staff Nurses.</b>										
41	49,200	51,660	54,120	56,580	59,040	61,500	63,960	66,420	68,880	71,340
<b>Staff Nurses.</b>										
42	37,800	40,320	42,840	45,360	47,880	50,400	52,920	55,440	57,960	60,480
<b>House Sister.</b>										
1	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740
<b>House Keeper.</b>										
1	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740
<b>Pharmacist.</b>										
1	720	756	792	828	864	900	936	972	1,008	1,044
<b>Laboratory Technicians.</b>										
3	2,160	2,340	2,520	2,700	2,880	3,060	3,240	3,420	3,600	3,780
<b>Caretaker.</b>										
1	480	504	528	552	576	600	624	648	672	696
<b>Laboratory attendants.</b>										
3	1,080	1,152	1,224	1,296	1,368	1,440	1,512	1,584	1,656	1,728
<b>Pharmacists.</b>										
16	7,680	8,064	8,448	8,832	9,216	9,600	9,984	10,368	10,752	11,136
<b>Ward attendants.</b>										
32	11,520	12,288	13,056	13,824	14,592	15,360	16,128	16,896	17,664	18,432
<b>Sweepers.</b>										
32	9,600	9,984	10,368	10,752	11,136	11,520	11,904	12,288	12,672	13,056
<b>Cooks.</b>										
16	5,760	6,144	6,528	6,912	7,296	7,680	8,064	8,448	8,832	9,216
<b>Mali.</b>										
4	1,200	1,248	1,296	1,344	1,392	1,440	1,488	1,536	1,584	1,632
<b>Mistrie.</b>										
1	480	504	528	552	576	600	624	648	672	696
<b>Clerk.</b>										
1	1,800	1,920	2,040	2,160	2,280	2,400	2,520	2,640	2,760	2,880
<b>Stenographer.</b>										
1	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740
<b>Clerk.</b>										
1	900	960	1,020	1,080	1,140	1,200	1,260	1,320	1,380	1,440
<b>Inferior Servants.</b>										
2	600	648	696	744	792	840	888	936	984	1,032



## SALARY OF STAFFS OF 200-BED HOSPITALS.

	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
First year ..	(216 × 1,81,435)	(216 × 1,92,636)	(216 × 2,03,837)	(216 × 2,15,039)	(216 × 2,26,240)	(216 × 2,37,441)	(150 × 2,70,013)	(144 × 2,92,762)	(144 × 2,95,512)	(77 × 3,08,260)
Second year ..	3,91,89,960	4,16,09,376	4,40,26,632	4,64,43,424	4,88,70,000	5,55,71,400	4,05,01,950	4,07,17,728	4,25,53,728	2,37,36,020
to Nil.										
Sixth year ..	..	..	..	..	..	..	..	..	..	..
Seventh year ..	..	..	..	..	..	..	..	..	..	..
Eighth year ..	..	..	..	..	..	..	..	..	..	..
Ninth year ..	..	..	..	..	..	..	..	..	..	..
Tenth year ..	..	..	..	..	..	..	..	..	..	..
1st five years	..	Ra. 22,01,44,392.	..	..	..	..	..	..	..	..
3,91,89,960	4,16,09,376	4,40,26,632	4,64,43,424	4,88,70,000	5,55,71,400	5,24,73,060	5,45,20,314	5,71,62,126	5,13,07,701	..
1st ten years	..	..	..	..	..	..	..	..	..	..
Second five years	..	..	..	..	..	..	..	..	..	..
1st ten years	..	..	..	..	..	..	..	..	..	..
Second five years	..	..	..	..	..	..	..	..	..	..
1st ten years	..	..	..	..	..	..	..	..	..	..
Second five years	..	..	..	..	..	..	..	..	..	..
1st ten years	..	..	..	..	..	..	..	..	..	..
Second five years	..	..	..	..	..	..	..	..	..	..
1st ten years	..	..	..	..	..	..	..	..	..	..
Second five years	..	..	..	..	..	..	..	..	..	..
1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
Second five years	..	..	..	..	..	..	..	..	..	..
1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
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1st ten years	..	..	..	..	..	..	..	..	..	..
Second five years	..	..	..	..	..	..	..	..	..	..
1st ten years	..	..	..	..	..	..	..	..	..	..
Second five years	..	..	..	..	..	..	..	..	..	..
1st ten years	..	..	..	..	..	..	..	..	..	..
Second five years	..	..	..							

*The Administrative organisation at the district headquarters.*

(Further details)

	Number	1st year	2nd year	3rd year	4th year	5th year	6th year	7th year	8th year	9th year	10th year
		Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
Officer-in-Charge of District Health Services @ Rs. 1,250-50-1,500 .. ..	1	15,000	15,600	16,200	16,800	17,400	18,000	18,000	18,000	18,000	18,000
Deputy (for the area outside the Scheme) @ Rs. 1,000-50-1,200 .. ..	1	12,000	12,600	13,200	13,800	14,400	14,400	14,400	14,400	14,400	14,400
Senior clerk, @ Rs. 150-10-250 .. ..	1	1,800	1,920	2,040	2,160	2,280	2,400	2,420	2,610	2,760	2,880
Statistical clerk @ Rs. 75-5-150 .. ..	1	900	960	1,020	1,080	1,140	1,200	1,260	1,320	1,380	1,440
Inferior servants @ Rs. 200-10-300 .. ..	3	2,400	2,500	2,640	2,660	2,880	3,000	3,120	3,240	3,360	3,488
Contingencies .. ..		800	972	1,044	1,116	1,188	1,260	1,332	1,404	1,476	1,548
Travelling allowances .. ..		2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Pension & leave salary .. ..		6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000
		9,234	9,474	9,713	9,953	10,192	10,499	10,566	10,633	10,700	10,767
<b>Total .. ..</b>		<b>50,234</b>	<b>52,046</b>	<b>53,867</b>	<b>55,669</b>	<b>57,480</b>	<b>58,759</b>	<b>59,198</b>	<b>59,637</b>	<b>60,076</b>	<b>60,515</b>

*Recurring Cost in respect of the District Headquarters organisation.*

	Rs.
<i>1st five years.</i> —	
One such organisation	2,60,286
216 such organisations	5,81,80,776
<i>2nd five years.</i> —	
One such organisation	2,98,185
216 such organisations	6,44,07,960
<i>1st ten years.</i> —	
For 216 District headquarters organisations	12,25,73,736

Five clerks (one for each primary unit) and one supervisor are provided for the first five primary units that will be set up in each district.

<b>Pay—</b>						<b>Rs.</b>
Supervisor .. .. .	..	..	..	..	..	78 p.m.
Travelling allowance .. .. .	..	..	..	..	..	25 p.m.
				<b>Total</b>	.	109 p.m.
Clerk .. .. .	..	..	..	..	..	60 p.m.
Travelling allowance .. .. .	..	..	..	..	..	20 p.m.
Contingencies .. .. .	..	..	..	..	..	8 p.m.
				<b>Total</b>	..	85 p.m.

(to cover all).

Province—	Total Cost.	
	Ten year period. Rs.	Five year period. Rs.
1. Madras .. .. .	8,91,360	3,31,200
2. Bombay .. .. .	4,73,100	2,62,200
3. Bengal .. .. .	10,45,200	3,58,800
4. U. P. .. .. .	11,95,200	6,62,400
5. Bihar .. .. .	6,26,880	2,20,800
6. Orissa .. .. .	1,49,400	82,800
7. Punjab .. .. .	7,16,400	3,83,400
8. C. P. & Berar .. .. .	3,92,160	2,23,440
9. Assam .. .. .	2,43,600	88,200
10. Sind .. .. .	1,03,680	50,400
11. N.-W. F. P. .. .. .	64,440	37,800
	<b>59,01,420</b>	<b>27,01,440</b>

Or roughly about

Rs. 60 lakhs.

**Rs. 28 lakhs.**

Year.	Each District	Expenses.
No. of primary units.		
Additional primary units each year.		
No. of clerks		
No. of supervisors.		
Total No. of clerks		
Total No. of supervisors		
Clerks Rs. (85+12+120)		
Supervisors Rs. (100×12×24)		
Total cost		

**MADRAS.**

[illegible]

Year.	Each District	Expenditure.
	No. of primary units.	
	Additional primary units. each year.	
	No. of clerks.	
	No. of supervisors.	
	Total No. of clerks.	
	Total No. of supervisors.	
	Clerks Rs. 85+12+120)	
	Supervisors Rs. (100×12× 24)	
	Total cost Rs.	

**BOMBAY.**

1st year	..	..	5	5	5	1	95	19	96,900	22,800	1,19,700
2nd year	..	..	5	..	..	..	..	..	..	..	..
3rd year	..	..	5	..	..	..	..	..	..	..	..
4th year	..	..	7	2	2	1	38	19	38,760	22,800	61,560
5th year	..	..	10	3	3	1	57	19	58,140	22,800	80,940
6th year	..	..	11	1	1	1	19	19	19,380	22,800	42,180
7th year	..	..	12	1	1	1	19	19	19,380	22,800	42,180
8th year	..	..	13	1	1	1	19	19	19,380	22,800	42,180
9th year	..	..	14	1	1	1	19	19	19,380	22,800	42,180
10th year	..	..	15	1	1	1	19	19	19,380	22,800	42,180
<b>Grand Total</b>										..	<b>4,73,100</b>

**BENGAL (26 Districts).**

[illegible]

### UNITED PROVINCES (48 Districts).

1st year	..	..	5	5	5	1	240	48	2,44,800	57,600	3,02,400
2nd year	..	..	5	..	..	..	..	..	..	..	..
3rd year	..	..	5	..	..	..	..	..	..	..	..
4th year	..	..	7	2	2	1	96	48	97,920	57,600	1,55,520
5th year	..	..	10	3	3	1	144	48	1,48,880	57,800	2,04,480
6th year	..	..	11	1	1	1	48	48	48,960	57,800	1,06,560
7th year	..	..	12	1	1	1	48	48	48,960	57,800	1,06,560
8th year	..	..	13	1	1	1	48	48	48,960	57,800	1,06,560
9th year	..	..	14	1	1	1	48	48	48,960	57,800	1,06,560
10th year	..	..	15	1	1	1	48	48	48,960	57,800	1,06,560
<b>Gand Total</b>										..	<b>11,95,200</b>

**BIHAR (16 Districts).**

<b>1st year</b>	..	..	5	5	5	1	80	16	81,600	19,200	1,00,800
<b>2nd year</b>	..	..	5	..	..	..	..	..	..	..	..
<b>3rd year</b>	..	..	5	..	..	..	..	..	..	..	..
<b>4th year</b>	..	..	7	2	2	1	32	16	32,640	19,200	51,840
<b>5th year</b>	..	..	10	3	3	..	48	16	48,960	19,200	68,160
<b>6th year</b>	..	..	13	3	3	1	48	16	48,960	19,200	68,160
<b>7th year</b>	..	..	17	4	4	1	64	16	65,280	19,200	84,480
<b>8th year</b>	..	..	21	4	4	1	64	16	85,280	19,200	84,480
<b>9th year</b>	..	..	25	4	4	1	64	16	65,280	19,200	84,480
<b>10th year</b>	..	..	29	4	4	1	64	16	65,280	19,200	84,480
<b>Grand Total ..</b>										<b>6,28,880</b>	







*Maintenance charges on capital works in connection with the three-million unit scheme.*

Year.			Capital expenditure	Maintenance at 3 per cent. per year.	
				1st five years.	1st ten years.
			Rs.	Rs.	Rs.
<b>Primary Units.</b>					
1st year	..	..	18,76,50,000	2,25,18,000	5,06,65,500
2nd year	..	..	..	..	..
3rd year	..	..	..	..	..
4th year	..	..	6,53,30,000	19,59,900	1,17,59,400
5th year	..	..	8,61,80,000	..	1,29,27,000
6th year	..	..	5,92,48,750	2,44,77,900	71,09,850
7th year	..	..	6,88,05,000		61,92,450
8th year	..	..	6,63,72,500		39,82,350
9th year	..	..	7,19,32,500		23,51,975
10th year	..	..	7,29,75,000		..
Total	..	..	..	..	9,49,88,525
<b>30-bed hospital.</b>					
1st year	..	..	3,00,78,000	36,09,360	81,21,060
2nd year	..	..	..	..	..
3rd year	..	..	..	..	..
4th year	..	..	2,61,79,000	7,85,370	47,12,220
5th year	..	..	..	..	..
6th year	..	..	3,27,23,750	43,94,730	39,26,850
7th year	..	..	3,92,68,500		35,34,165
8th year	..	..	3,81,54,500		22,89,270
9th year	..	..	5,11,04,750		15,33,142
10th year	..	..	5,95,99,000		..
Total	..	..	..	..	2,41,16,707
<b>Secondary Unit.</b>					
1st year	..	..	3,78,00,000	45,36,000	1,02,06,000
2nd year	..	..	..	..	..
3rd year	..	..	..	..	..
4th year	..	..	..	..	..
5th year	..	..	..	..	..
6th year	..	..	34,56,000	45,36,000	4,14,720
7th year	..	..	1,15,50,000+ 10,56,000 =1,26,06,000		11,34,540
8th year	..	..	10,50,000+ 96,000 =11,46,000		68,760
9th year	..	..	..	..	..
10th year	..	..	1,17,25,000+ 10,72,000 =1,27,97,000		..
Total	..	..	..	..	1,18,24,020

*Maintenance charges on non-recurring expenditure.*

Year.			Capital expendi- ture.	Maintenance at 3 per cent. per years.	
				1st five years.	1st ten years.
<b>200-bed hospital.</b>					
1st year	..	..	30,79,62,000	3,69,55,440	8,31,49,740
2nd year	..	..	..	..	..
3rd year	..	..	..	..	..
4th year	..	..	..	..	..
5th year	..	..	..	..	..
6th year	..	..	96,12,000	3,69,55,440	11,53,440
7th year	..	..	..		..
8th year	..	..	..		..
9th year	..	..	..		..
10th year	..	..	..		..
Total	..	..	..	..	8,43,03,180
<b>600-Bed hospital.</b>					
1st year	..	..	..		..
2nd year	..	..	..		..
3rd year	..	..	..		..
4th year	..	..	..		..
5th year	..	..	..		..
6th year	..	..	..		..
7th year	..	..	21,58,20,000 + 46,20,000 =22,04,40,000		1,98,39,600
8th year	..	..	1,96,20,000 + 4,20,000 =2,00,40,000		12,02,400
9th year	..	..	Nil		..
10th year	..	..	21,90,90,000 + 46,90,000 =22,37,80,000		
Total	..	..	..	..	2,10,42,000
For the second five or 1st ten years.					

No. of districts.	Madras. Bombay. Bengal. U. P. Bihar. Orissa. Punjab. C. P. & Berar. Assam. Sind. N. W. F. P.										Total eleven Provinces.	Increase from year to year.	
	24	19	26	48	16	6	30	19	14	8	6	216	
1st year ..	120	95	130	240	80	30	180	95	70	40	30	1,080	1,080
2nd " ..	120	95	130	240	80	30	150	95	70	40	30	1,080	..
3rd " ..	120	95	130	240	80	30	150	95	70	40	30	1,080	..
4th " ..	188	133	182	336	112	42	210	133	70	40	30	1,456	376
5th " ..	240	190	280	480	100	60	270	152	70	40	30	1,952	496
6th " ..	312	209	364	528	208	68	300	152	84	40	30	2,293	341
7th " ..	384	228	468	576	272	78	330	171	98	48	36	2,689	396
8th " ..	456	247	572	624	336	90	360	190	112	48	36	3,071	382
9th " ..	552	200	676	672	400	102	390	209	126	56	36	3,485	414
10th " ..	648	285	780	720	464	114	420	228	140	64	42	3,905	420

*Numbers of 30-bed hospitals during the first ten years in British India.*

(Provision in respect of these hospitals has been doubled during the second five years).

No. of Districts.	Mad. Bom. ras. Bay. Bengal. U. P. Bihar. Orissa. Pun. C. P. & Assam. Sind. F. P. Jab. Berar.										Total eleven Provinces.		Increase from year to year.
	24	19	20	48	16	6	30	19	14	8	6	216	
1st year	24	19	26	48	16	6	30	19	14	8	6	216	216
2nd " "	24	19	26	48	16	6	30	19	14	8	6	216	..
3rd " "	24	19	26	48	16	6	30	19	14	8	6	216	..
4th " "	48	38	52	96	32	12	60	38	14	8	6	404	188
5th " "	48	38	52	96	32	12	60	38	14	8	6	404	..
6th " "	96	57	104	144	64	18	90	38	14	8	6	639	235
7th " "	144	76	156	192	96	24	120	57	28	16	12	921	282
8th " "	192	95	208	240	128	36	150	76	42	16	12	1,195	274
9th " "	264	133	286	288	170	48	180	95	56	24	12	1,562	367
10th " "	336	152	390	384	224	60	210	114	70	32	18	1,990	428

*Number of secondary units in British India, during the first ten years period.*

No. of Dis- tricts.	Mad- ras.			Bom- bay.			Bengal.			U. P.			Bihar.			Orissa.			Pun- jab.			C. P. & Berar.			Assam.			Sind.			N. W. F. P.			Total 11 Pro- vinces.	Increase from year to year.
	24	19	26	48	16	6	30	19	14	8	6	216																							
1st year	24	19	26	48	16	6	30	19	14	8	6	216	216																						
2nd " "	24	19	26	48	16	6	30	19	14	8	6	216	..																						
3rd " "	24	19	26	48	16	6	30	19	14	8	6	216	..																						
4th " "	24	19	26	48	16	6	30	19	14	8	6	216	..																						
5th " "	24	19	26	48	16	6	30	19	14	8	6	216	..																						
6th " "	24	19	26	48	16	6	30	19	14	8	6	216	..																						
7th " "	48	19	52	48	32	6	30	19	14	8	6	282	66																						
8th " "	48	19	52	48	32	12	30	19	14	8	6	288	6																						
9th " "	48	19	52	48	32	12	30	19	14	8	6	288	..																						
10th " "	48	38	52	96	32	12	30	19	14	8	6	355	67																						

*Number of 200-bed and 500-bed hospitals in British India, during the First Ten years.*

No. of Districts.	Madras 24	Bombay 19	Bengal 26	U. P. 48	Bihar 16	Orissa 6	Punjab 30	C. P. & Berar 19	Assam 14	Sind 8	N. W. F. P. 16	Total 216
Year.												
1st year	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.	200. 500. bed hospi- tal.
2nd year	24 ..	19 ..	26 ..	48 ..	16 ..	6 ..	30 ..	19 ..	14 ..	8 ..	6 ..	216 ..
3rd year	24 ..	19 ..	26 ..	48 ..	16 ..	6 ..	30 ..	19 ..	14 ..	8 ..	6 ..	216 ..
4th year	24 ..	19 ..	26 ..	48 ..	16 ..	6 ..	30 ..	19 ..	14 ..	8 ..	6 ..	216 ..
5th year	24 ..	19 ..	26 ..	48 ..	16 ..	6 ..	30 ..	19 ..	14 ..	8 ..	6 ..	216 ..
6th year	24 ..	19 ..	26 ..	48 ..	16 ..	6 ..	30 ..	19 ..	14 ..	8 ..	6 ..	216 ..
7th year	24 ..	19 ..	26 ..	48 ..	16 ..	6 ..	30 ..	19 ..	14 ..	8 ..	6 ..	216 ..
8th year	24 ..	19 ..	26 ..	48 ..	16 ..	6 ..	30 ..	19 ..	14 ..	8 ..	6 ..	216 ..
9th year	24 ..	19 ..	26 ..	48 ..	16 ..	6 ..	30 ..	19 ..	14 ..	8 ..	6 ..	216 ..
10th year	24 ..	19 ..	26 ..	48 ..	16 ..	6 ..	30 ..	19 ..	14 ..	8 ..	6 ..	216 ..

*Housing of the staff.*

		Rs.	Rs.	Rs.
<b>I.—Primary Units—</b>				
1st year	..	1,080 × 1,38,750 =	14,98,50,000	..
2nd "	..	..	..	..
3rd "	..	..	..	..
4th "	..	376 × 1,38,750 =	5,21,70,000	..
5th "	..	496 × 1,38,750 =	6,88,20,000	27,08,40,000
6th "	..	341 × 1,38,750 =	4,73,13,750	..
7th "	..	396 × 1,38,750 =	5,49,45,000	..
8th "	..	382 × 1,38,750 =	5,30,02,500	..
9th "	..	414 × 1,38,750 =	5,74,42,500	..
10th "	..	420 × 1,38,750 =	5,82,75,000	54,18,18,750

**II.—30-bed hospitals—**

1st year	..	216 × 84,250 =	1,81,98,000	..
2nd "	..	..	..	..
3rd "	..	..	..	..
4th "	..	188 × 84,250 =	1,58,39,000	..
5th "	..	..	..	3,40,37,000
6th "	..	235 × 84,250	1,97,98,750	..
7th "	..	282 × 84,250 =	2,37,58,500	..
8th "	..	274 × 84,250 =	2,30,84,500	..
9th "	..	367 × 84,250 =	3,09,19,750	..
10th "	..	428 × 84,250 =	3,60,59,000	16,76,57,500

**Secondary Units—**

1st year	..	216 × 1,45,000 =	3,13,20,000	..
2nd to 5th year	..	..	..	3,13,20,000
6th year (Dental)	..	216 × 16,000 =	34,56,000	..
7th "	..	66 × (1,45,000 + 16,000) =	1,06,28,000	..
8th "	..	6 × 1,61,000 =	966,000	..
9th "	..	..	..	..
10th "	..	67 × 1,61,000 =	1,07,87,000	5,71,55,000

**300-bed Hospital  
(inclusive of Dental)**

$$216 \times (6,25,750 + 44,500) = 14,47,74,00$$

1st five and ten years.

**500-bed Hospitals**

(inclusive of Dental)				
7th year	..	66 × 12,70,000 =	8,44,40,400	..
8th "	..	6 × 13,40,000	80,40,300	..
9th "	..	..	..	1st ten years
10th "	..	67 × 13,40,000 =	8,97,80,000	18,62,60,000

**Total cost of accommodation for all**

<b>1st five years</b>	<b>2nd five years</b>	<b>1st ten years.</b>
Rs.	Rs.	Rs.
48,09,71,000	61,66,94,250	109,76,65,250

## PRELIMINARY SURVEYS.

Before starting the proposed health developments it is desirable to have a survey to find out existing health conditions. If such a survey can be carried out in every district where the scheme is to be introduced we shall have reached the ideal arrangement. However, particularly in view of the trained staff necessary this may not be possible. It is therefore suggested that such surveys should be carried out in the areas under our scheme in four districts in each province, which are selected as being representative of the conditions prevailing in the province as a whole. In Singur, for a population of about 62,100, it is understood that the survey cost Rs. 16,000. Therefore the survey in each district will cost roughly Rs. 50,000 and in each province Rs. *two lakhs*. For eleven Provinces this cost will be Rs. *22 lakhs*.

It is desirable that health surveys should be accompanied by similar surveys in other fields such as agriculture, animal husbandry, education, etc.

*Non-recurring.**Water Supply*

## 1st five years—

			Rs.	
Urban	..	..	10,00,00,000	} Maintenance at 3% per year Rs. 1,20,00,000.
Rural	..	..	10,00,00,000	

## 2nd five years—

Urban	..	..	10,00,00,000	} On previous periods expenditure 3,00,00,000. On 2nd five years' expenditure Rs. 1,20,00,000.
Rural	..	..	10,00,00,000	

## Ten years—

Urban	..	..	20,00,00,000	} Maintenance total Rs. 5,40,00,000.
Rural	..	..	20,00,00,000	

*Drainage—*

1st five years	..	..	30,00,00,000	} Maintenance 1st five years .. .. 1,80,00,000 1st ten years .. .. 8,10,00,000
1st ten years	..	..	60,00,00,000	

Total maintenance on water supply and drainage together :

			Rs.
1st five years	..	..	1,20,00,000
			1,80,00,000
			<hr/> 3,00,00,000
1st ten years	..	..	5,40,00,000
			8,10,00,000
			<hr/> 13,50,00,000

*Recurring.*

Rs.

**1st five years—**

Water and Drainage Board, Investigation units @ Rs. 2.6 lakhs per year .. .. . 13,00,000

**1st five years—**

Water and Drainage Board, Investigation units @ Rs. 2.6 lakhs per year 13,00,000

**1st ten years—**

Rs. 13,00,000 plus Rs. 13,00,000 .. .. . 26,00,000

*Central Directorate—*

					1st five years.	1st ten years.
					Rs.	Rs.
Officers	..	..	..	..	37,00,000	82,50,000
Establishment	..	..	..	..	8,00,000	18,00,000
Travelling allowances	..	..	..	..	6,25,000	12,50,000
<b>Total</b>					<b>51,25,000</b>	<b>1,13,00,000</b>

*Provincial Directorate—*

					1st five years.	1st ten years.
					Rs.	Rs.
Officers	..	..	..	..	2,93,81,550	5,89,28,100
Establishment	..	..	..	..	44,90,000	94,00,000
Travelling allowance	..	..	..	..	46,75,000	93,50,000
<b>Total</b>					<b>3,84,56,050</b>	<b>7,77,38,100</b>

**CENTRAL DIRECTORATE.**

Name.	No.	Scale of pay.
<b>STAFF—</b>		
Director General of Health Services	1	Rs. 3,500 per mensem.
Deputy Directors	6	Rs. 2,750 per mensem.
Assistant Directors	14	Rs. 1,900—50—2,100.

**PROVINCIAL DIRECTORATE.**

Name.	No.	Scale of pay.
<b>STAFF—</b>		
Director of Health Services	1	Rs. 2,750 per mensem.
Deputy Directors	5	Rs. 2,000—50—2,500.
Assistant Directors	14	Rs. 1,500—50—1,750.

**CENTRAL DIRECTORATE**  
(Further details)

Num- ber	1st year	2nd year	3rd year	4th year	5th year	6th year	7th year	8th year	9th year	10th year
	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
Director General of Health Services @ Rs. 3,500/- p.m.	42,000	42,000	42,000	42,000	42,000	42,000	42,000	42,000	42,000	42,000
Deputy Directors @ Rs. 2,750/- p.m. . . . .	1,98,000	1,98,000	1,98,000	1,98,000	1,98,000	1,98,000	1,98,000	1,98,000	1,98,000	1,98,000
Assistant Directors @ Rs. 1,900/-50-2,100 . . . . .	3,19,200	3,27,600	3,36,000	3,44,400	3,52,800	3,52,800	3,52,800	3,52,800	3,52,800	3,52,800
Pension & Leave Charges — Pension @ Rs. 176 p.m. 'per officer . . . . .	44,352	44,352	44,352	44,352	44,352	44,352	44,352	44,352	44,352	44,352
Leave salary @ 15% . . . . .	88,880	85,140	86,400	87,660	88,920	88,920	88,920	88,920	88,920	88,920
	6,87,432	6,97,092	7,06,752	7,16,412	7,26,072	7,26,072	7,26,072	7,26,072	7,26,072	7,26,072
	Roughly Rs. 37,00,000									
	Roughly Rs. 45,50,000									
Establishment. . . . .	1,60,000	1,60,000	1,60,000	1,60,000	1,60,000	2,00,000	2,00,000	2,00,000	2,00,000	2,00,000
Total . . . . .	8,47,432 or roughly 9,00,000	8,57,092	8,66,762	8,76,412	8,86,072	9,48,572	9,48,572	9,48,572	9,48,572	9,48,572
	1st five years total—45,00,000									
	2nd five years total—47,50,000									
Travelling allowances. . . . .	1,25,000	1,25,000	1,25,000	1,25,000	1,25,000	1,25,000	1,25,000	1,25,000	1,25,000	1,25,000
	1st five years total—6,25,000									
	2nd five years total—6,25,000									





## MALARIA (TOTAL EXPENDITURE).

			1st five years Rs.	1st ten years Rs.
<b>Non-recurring :</b>				
Centre ..	..	..	1,46,800	2,66,800
Provinces ..	..	..	7,70,000	17,60,000
Total ..			<u>9,15,800</u>	<u>20,26,800</u>
<b>Recurring :</b>				
Centre ..	..	..	47,18,284	1,32,87,136
Provinces ..	..	..	<u>2,04,89,326</u>	<u>5,04,22,361</u>
Total ..		Rs.	<u>2,52,07,610</u>	<u>6,37,09,497</u>

## Centrally Administered Areas.

Non-recurring—details of the above expenditure.

## 1st five years :

## Headquarters Organisation.

For one Governor's Province ..	Rs. 10,000	
For one Centrally Administered Province ..	2/3 (10,000)	=Rs. 6,700
For four Centrally Administered Provinces ..		= Rs. 26,800
Maintenance ..	Rs. 1,608	

## Malaria Control Units :

For one control unit ..	Rs. 6,000	
For five control units in each of these areas .. (6,000×5)		=Rs. 30,000
In all the four areas (30,000×4)		= Rs. 1,20,000
Total non-recurring expenditure (1st five years) ..		= Rs. 1,46,800
Maintenance ..	Rs. 7,200	
Total Maintenance ..		<u>Rs. 8,808</u>

## 2nd five years :

Headquarters' Organisation .. Nil

Malaria Control Units—There are established five additional control units in each area. Total non-recurring expenditure for them will be				Rs.	Rs. 1,20,000
Maintenance—Headquarters ..	..	..	4,020	Total	Rs. 2,68,800
Malaria Control Units (old) ..	..	..	18,000		
Malaria Control Units (new) ..	..	..	7,200		
Total ..	..	..			<u>29,220</u>
Total maintenance for the first ten years ..					<u>88,028</u>

**MALARIA—contd.****Provinces.****(Non-recurring)**

At each headquarters Rs. 10,000 for non-recurring contingencies have been provided, so, for the eleven provinces a sum of Rs. 1,10,000 has been provided.

For ten control units in each province we have provided a sum of Rs. 60,000. And for the eleven Provinces this sum will be Rs. 6,60,000.

In this way a sum of Rs. 7,70,000 for non-recurring expenditure for Malaria, in the first five years, has been included in the estimates.

Maintenance at 3 p. c. per year on the above sum .. Rs. 46,200

In the second five years for additional fifteen control units we have provided a sum of Rs. 9,90,000, on the above basis.

Total for ten years .. .. .	Rs. 9,90,000
	Rs. 6,60,000
Headquarters.. .. .	Rs. 16,50,000
	1,10,000
	Rs. 17,60,000
Maintenance .. .. .	Rs. 2,21,100

**RECURRING (Centre).****1st five years :**

	Rs.
Salaries of staff of headquarter's organisation of one Governor's Province .. .. .	3,63,816
Salaries of staff for the Centrally Administered Area=2/3 × 3,63,816 .. .. .	2,42,544
Salaries of staff for four areas .. .. .	9,70,176
	Rs.
Salaries of staff of one Malaria Control Unit ..	1,49,465
Salaries of staff of five Malaria Control Units (or one Centrally Administered area) .. .. .	7,47,325
Salaries of staff for four such areas .. .. .	29,89,300
Total salaries for the first five years .. .. .	39,59,476
Total maintenance .. .. .	8,808
Malaria Institute of India @ Rs. 1.5 lakhs per year .. .. .	7,50,000
Total .. .. .	47,18,284

**2nd five years :**

	Rs.
Staff salaries for one unit for a Governor's Province	4,57,256
Staff salaries of one unit for a Centrally Administered Area .. .. .	3,04,838
Staff salaries of four Central Administered Areas ..	12,15,352
Staff salaries of one Malaria Control Unit ..	1,79,249
Staff salaries of five Malaria Control Units ..	8,96,245
Staff salaries of all the four Areas .. ..	35,84,980
Staff salaries of the four areas with five new malaria control units established .. ..	29,89,300
<b>Total salaries (second five years) .. ..</b>	<b>77,89,632</b>
<b>Total maintenance .. .. .</b>	<b>29,220</b>
<b>Malaria Institute of India @ 1.5 lakhs per year ..</b>	<b>7,50,000</b>
<b>Total ..</b>	<b>85,68,852</b>
<b>Total for the 1st ten years ..</b>	<b>1,32,87,136</b>

**RECURRING (Provinces).**

**(Recurring)**

	Rs.
Salaries of staff of the headquarters organisation (Malaria) for the first five years .. ..	3,63,816
For eleven Provinces (3,63,816 × 11) .. ..	40,01,976
For one control unit (salary of staff) .. ..	1,49,465
For ten (in each Province) .. .. .	14,94,650
Eleven Provinces .. .. .	1,64,41,150
<b>Total for the first five years .. .. .</b>	<b>1,64,41,150</b>
	<b>40,01,976</b>
	<b>2,04,43,126</b>
<b>Maintenance .. .. .</b>	<b>46,200</b>
	<b>2,04,89,326</b>

**(Recurring)**

**Ten years :**

	Rs.
For fifteen additional control units in each province	22,41,975
Eleven Provinces .. .. .	2,46,61,725
For additional two D.A.D.P.H.'s and their organisations (72,020 × 11) .. .. .	7,92,220
Expenditure on previous period's organisations Headquarters Rs. 4,57,256 × 11 .. ..	50,29,816
Control units 1,79,249 × 10 × 11 .. ..	1,97,17,390
<b>Total for ten years .. .. .</b>	<b>5,02,01,261</b>
<b>Maintenance .. .. .</b>	<b>2,21,100</b>
	<b>5,04,22,361</b>

Staff in respect of the headquarters, regional and control unit organisation

**Malaria—contd.**  
(Further details).

Name.	No.	Scale of pay.
Rs.		
<b>Headquarters organisation :—</b>		
Malariologist .. .. .	1	600—40—1,000
Entomologist .. .. .	1	325—25—650—35—1,000
Sanitary Engineer .. .. .	1	325—25—650—35—1,000
Overseers .. .. .	4	100—5—220
Draftsman .. .. .	1	75—3—135
Antimalaria Officer .. .. .	1	325—25—650—35—1,000
Laboratory assistants .. .. .	5	50—5—150
Antimalaria assistants .. .. .	2	350—25—750
Clerks .. .. .	3	50—5—150
Insect collectors .. .. .	8	30—1—50
Inferior servants .. .. .	2	25—2—55
Sweepers .. .. .	2	25—1—35
<b>Regional organisation :—</b>		
Deputy .. .. .	3	325—25—650—35—1,000
Clerks .. .. .	2	50—5—150
<b>Malaria Control Units :—</b>		
Antimalaria assistant .. .. .	1	250—25—500
Laboratory assistants .. .. .	2	50—5—150
Malaria supervisors .. .. .	5	75—3—90—4—150
Mistrie .. .. .	1	40—2—60
Field workers .. .. .	25	25—1—35

**MALABAR (FORTIFIED DETAILS—contd.)**  
**TOTAL SALARIES OF A HEADQUARTERS UNIT OF 'MALABAR ORGANISATION DURING A PERIOD OF TEN YEARS.**

	Number.	1st year. Rs.	2nd year. Rs.	3rd year. Rs.	4th year. Rs.	5th year. Rs.	6th year. Rs.	7th year. Rs.	8th year. Rs.	9th year. Rs.	10th year. Rs.
<b>Headquarter Unit.</b>											
Malariaologist.	..	1	7,200	7,880	8,160	8,640	9,120	9,600	10,080	11,040	11,520
@ Rs. 600—40—1,000	..	..	..	..	..	..	..	..	..	..	..
Entomologist.	..	1	3,900	4,200	4,500	4,800	5,100	5,400	5,700	6,300	6,600
@ Rs. 325—25—650—35—1,000	..	..	..	..	..	..	..	..	..	..	..
Sanitary Engineer.	..	1	2,900	4,200	4,500	4,800	5,100	5,400	5,700	6,300	6,600
@ Rs. 225—25—650—35—1,000	..	..	..	..	..	..	..	..	..	..	..
Overseer.	..	4	4,800	5,040	5,280	5,520	5,760	6,000	6,240	6,480	6,960
@ Rs. 100—5—200	..	..	..	..	..	..	..	..	..	..	..
Draftsman.	..	1	900	936	972	1,008	1,044	1,080	1,116	1,152	1,224
@ Rs. 75—3—135	..	..	..	..	..	..	..	..	..	..	..
Antimalaria Officer.	..	1	3,900	4,200	4,500	4,800	5,100	5,400	5,700	6,300	6,600
@ Rs. 325—25—650—35—1,000	..	..	..	..	..	..	..	..	..	..	..
Antimalaria Assistants	..	2	6,000	6,600	7,200	7,800	8,400	9,000	9,600	10,200	11,400
@ Rs. 350—25—750	..	..	..	..	..	..	..	..	..	..	..
Laboratory Assistants.	..	5	3,000	3,300	3,600	3,900	4,200	4,500	4,800	5,100	5,700
@ Rs. 50—5—150	..	..	..	..	..	..	..	..	..	..	..
Clerks.	..	3	1,800	1,980	2,160	2,340	2,520	2,700	2,880	3,060	3,420
@ Rs. 50—5—150	..	..	..	..	..	..	..	..	..	..	..
Insect Collectors.	..	8	2,880	2,976	3,072	3,168	3,264	3,360	3,456	3,552	3,744
@ Rs. 30—1—50	..	..	..	..	..	..	..	..	..	..	..
Inferior Servants.	..	2	600	648	696	744	792	840	888	936	1,032
@ Rs. 25—2—55	..	..	..	..	..	..	..	..	..	..	..
Sweepers.	..	2	600	648	696	744	792	840	888	936	1,032
@ Rs. 25—1—35	..	..	..	..	..	..	..	..	..	..	..
Travelling allowance	..	..	7,800	7,800	7,800	7,800	7,800	7,800	7,800	7,800	7,800
@ Rs. 30—1—50	..	..	..	..	..	..	..	..	..	..	..
Contingencies (recurring)	..	..	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
@ Rs. 25—2—55	..	..	..	..	..	..	..	..	..	..	..
Leave & pension charges	..	..	7,896	8,722	9,547	10,373	11,198	12,024	12,850	13,675	15,326
..	..	65,176	68,930	72,683	76,437	80,190	83,944	87,698	91,451	95,205	98,958



## TUBERCULOSIS.

**I. Hospitals and clinics :—**Tuberculosis hospitals of 200 beds are to be established for units of 10 million population.

33 such hospitals are required for British India by 1951 (estimated population 330 millions).

A central clinic located in the same city as the hospital and smaller clinics at the headquarters of each district are required. The estimates of cost, recurring and non-recurring, for all these institutions are given below :—

*Estimates.*

		Number of institutions.	Cost.	
			Non-recurring. in lakhs. (Rs. 1,500 per bed).	Recurring. in lakhs. (Rs. 900 per bed).
200-bed hospitals .. ..	..	33	99.0	59.40
Main clinics .. ..	..	33	33.0 (at one lakh for each).	8.91 (at Rs. 27,000 for each.)
District clinics. (216 districts in the 11 Governors' Provinces).	..	183	82.35 (Rs. 45,000 for each).	20.28 (Rs. 16,000 for each).
Total .. ..	..	249	214.35	97.69

The main clinics located in the cities in which the hospitals are established will be equipped and staffed on a more generous scale than the district clinics. The former will serve as training centres for doctors and health visitors ; the numbers to be trained to meet the requirements of the country are estimated to be 13,000 doctors and 10,000 health visitors.

*Strength of staff required for these institutions :—*

Each 200-bed hospital will require specially trained doctors at the rate of one doctor per 30-beds or 7 in all.

In the early stages it may be necessary to have 4 doctors specially trained in tuberculosis and 3 untrained ones.

The main clinics located in the cities in which the hospitals are established will require three doctors each. In the beginning they may be two trained and one untrained.

Each district clinic will require 2 doctors, in the initial stages one trained and the other untrained.



A statement showing the strength of the staff required is given below :—

Type of institution.	No. of Institutions.	Number of trained doctors required.	Strength of staff required (doctors).	
			Early stages.	
			Trained.	Untrained.
200-bed hospitals .. ..	33	231 (7 for each).	132 (4 for each).	99 (3 for each).
Main clinics .. ..	33	99 (3 for each).	66 (2 for each).	33 (1 for each).
District clinics .. ..	183	366 (2 for each).	183 (1 for each).	183 (1 for each).
	249	696	381	315

## II.—TRAINING FACILITIES.

### (a) Training of doctors.

Eight new training centres have been recommended by the Tuberculosis Sub-committee. Of these one relates to Hyderabad and its cost must be deducted. The total cost in respect of the 8 new centres is 32 lakhs (non-recurring) and Rs. 13 lakhs per year (recurring). Reducing these by 1/8th the figures become.—

Non-recurring. (in lakhs).	Recurring. (in lakhs).
Rs.	Rs.
28	11·375

### (b) Training of health visitors.

Public health nurses, when trained, will take the place of health visitors. These public health nurses will perform various personal health services such as those associated with maternity and child welfare, school health, tuberculosis, venereal diseases, etc. It is considered that ordinarily public health nurses should have special training in tuberculosis for a period of three months.

Three health visitors are required for each of the main clinics and two for each of the district clinics. The total numbers required are shown below :—

Type of institution.	No. of institutions.	No. of health visitors required
Main clinics .. ..	33	99 (3 for each).
District clinics .. ..	183	366 (2 for each).
	216	465

### Number of doctors trained in the first five years.

The existing institutions will train 75 doctors per year. Therefore within the first five years period  $75 \times 4$  (or 300) trained doctors will be provided by the existing institutions.

(Note that the batch trained in the 5th year will not be available for service in the 5th year period).

During the same period of five years the 7 new centres (Hyderabad is excluded) may function on an average only for three years (they will take time to be established) and two batches of students may alone undergo training. The period of training is actually 9 months but it is expected that there will be only one course each year. If each of the new institutions makes available 12 trained doctors per year their total contribution within the five-year period will be 168. Therefore the total number of trained doctors available within the five-year period will be 468 (300 plus 168).

It will be seen that, if the proposals outlined above for filling only a certain proportion of the posts by doctors with special training in tuberculosis during the first five-year period be accepted, the training facilities outlined above will suffice to provide the staff required for the suggested expansion of tuberculosis medical institutions.

As regards health visitors the question of training public health nurses has been considered elsewhere. The required number can be made available.

### III.—STIPENDS FOR DOCTORS AND HEALTH VISITORS.

Rs. 50 for doctors and Rs. 25 for health visitors are suggested as stipends. The period of training for a doctor is 9 months and that for a health visitor three months.

Cost of stipends for doctors and health visitors.

For 468 doctors at Rs. 50 per month for nine months .. .. 2·106 lakhs.

For 500 health visitors at Rs. 25 per month for three months .. 0·375 lakhs.

(467 are actually required, the remainder is provided for possible wastage during training)

		2·481 or
Total ..		roughly 2·50 lakhs.

### IV.—OTHER ITEMS OF EXPENDITURE.

Other items of expenditure include travelling expenses for poor patients, help to indigent families, aftercare, publicity, etc. On the basis of Rs. 23,500 per annum for a population of three millions suggested by the Tuberculosis Sub-committee the estimate of cost, under these heads, for British India (315 millions) during the first five years will be Rs. 25·85 lakhs.

## TUBERCULOSIS.

Estimates of cost in respect of our proposals relating to tuberculosis.

<i>1st five years.</i>	<i>Non-recurring.</i> Rs.	<i>Recurring.</i> Rs.
1. Hospitals & clinics .. ..	2,14,35,000	4,87,95,000
2. Training of doctors and health visitors..		
(a) Training institutions .. ..	28,00,000	56,87,500
(b) Stipends for doctors and health visitors ..	..	2,50,000
3. Other items of expenditure .. ..	..	25,85,000
<b>Total</b> ..	<b>2,42,35,000</b>	<b>5,73,17,500</b>
<b>Maintenance on non-recurring expenditure</b>		
@ 3 per cent. per year .. ..	..	14,54,100
<b>Total</b> ..	..	<b>5,87,71,600</b>

*Stipends in the 2nd five years.*

45 institutions will be imparting training to doctors.

Number to be made available  $45 \times 12 =$

Stipends—Doctors  $540 \times 50 \times 9$  months—

Health visitors  $600 \times 25 \times 3$  months—

540  
Rs. 2 43 lakhs.  
0.45 „

Rs. 2.88 or  
Rs. 3 lakhs.

<i>2nd five years.</i>	<i>Non-recurring.</i> Rs.	<i>Recurring.</i> Rs.
1. Hospitals & clinics .. ..	2,14,35,000	4,87,95,000
2. Training of doctors and health visitors..		
(a) training institutions .. ..		56,87,500
(b) stipends .. ..		3,00,000
3. Other items of expenditure .. ..		25,85,000
4. Maintenance on non-recurring expenditure ..		49,21,350
5. Travelling tuberculosis clinics .. ..	1,59,75,000	3,71,15,842
<b>Total</b> ..	<b>3,74,10,000</b>	<b>9,94,04,692</b>
<b>1st five years</b> .. ..	<b>2,42,35,000</b>	<b>5,87,71,600</b>
<b>Total for 1st ten years</b> .. ..	<b>6,16,45,000</b>	<b>15,81,76,292</b>

## TRAVELLING TUBERCULOSIS CLINICS.

*N.B.*—These clinics will be brought into existence in the second five-year period of the scheme. In the 6th and 7th years of the scheme one such clinic will be attached to each secondary unit, whereas in the 8th, 9th and 10th years two such units will be associated with one secondary unit.

*Non-recurring expenditure—**One unit—*

			Rs.
Car with general equipment	..	..	15,000
X-Ray unit	..	..	8,000
Laboratory equipment	..	..	1,500
Total	..	..	22,500

*Total non-recurring expenditure—*

		No. of clinics started	Addition- al clinics.	Cost. Rs.
One clinic to each secondary unit.	6th year	216	..	48,60,000
	7th year	..	66	14,85,000
Two clinics to each secondary unit.	8th year	..	294	66,15,000
	9th year	..	..	.
	10th year	..	134	30,15,000
Total	..	..	..	1,59,75,000

*Recurring expenditure—*

			Rs.*
6th year	..	..	31,97,664
7th year	..	..	43,11,672
8th year	..	..	88,42,620
9th year	..	..	92,07,738
10th year	..	..	1,15,56,148
Total	..	..	3,71,15,842

(\* Details given below).

		6th year. Rs.	7th year. Rs.	8th year. Rs.	9th year. Rs.	10th year Rs.
One clinic to each secondary unit.	6th year	(216 × 14,804) 31,97,664	(216 × 15,438) 33,34,608	(216 × 16,071) 34,71,336	(216 × 16,705) 36,08,280	(216 × 17,338) 37,43,008
	7th year	..	(66 × 14,804) 9,77,064	(66 × 15,438) 10,18,908	(66 × 16,071) 10,60,686	(66 × 16,705) 11,02,530
	8th year	..	..	[(282 + 12) 43,52,376]	(294 × 15,438) 45,38,772	(294 × 16,071) 47,24,874
Two clinics to each secondary unit.	9th year	..	..	..	..	(2 × 67 × 14,804) 19,83,736
	10th year	..	..	..	..	..
Total	..	31,97,664	43,11,672	88,42,620	92,07,738	1,15,56,148

Total of five years.=Rs. 3,71,15,842.

## TRAVELLING TUBERCULOSIS CLINICS.

Salaries, etc., of the staff.	1st year.	2nd year.	3rd year.	4th year.	5th year.
	Rs.	Rs.	Rs.	Rs.	Rs.
1 M.O. at Rs. 250—25—500	3,000	3,300	3,600	3,900	4,200
1 X-Ray technician at Rs. 150—10—250 ..	1,800	1,920	2,040	2,160	2,280
1 Nurse at Rs. 75—5—125 ..	900	960	1,020	1,080	1,140
2 Attendants at Rs. 30—2—50	720	768	816	864	912
Leave salary & pension charges	1,284	1,390	1,495	1,601	1,708
Recurring annual expenditure on the Laboratory ..	3,000	3,000	3,000	3,000	3,000
Propaganda and publicity ..	500	500	500	500	500
Maintenance, transportation and depreciation charges at Rs. 300 p.m. ..	3,600	3,600	3,600	3,600	3,600
Total ..	14,804	15,438	16,071	16,705	17,338



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*Estimates of Expenditure on Mental Institutions.*

First five years.

(1) Improvements in mental hospitals.				Non-recurring.	Recurring.
				Ra.	Ra.
(a)	Madras	..	..	10,00,000	
(b)	Poona	..	..	10,00,000	
(c)	Agra	..	..	25,00,000	
(d)	Nagpur	..	..	25,00,000	
(e)	Lahore				
	(new hospital 1,500 beds)	..		50,00,000	
(f)	Ranchi				
	(European Mental Hospital)	..		10,00,000	
(g)	Ranchi				
	(Indian Mental Hospital)	..		10,00,000	
(h)	Thana				
	(Converted into Mental Deficiency or Senile Home)	..	..	5,00,000	
				<hr/>	
				1,45,00,000	
				<hr/>	
(2) Opening of two new mental hospitals in Bombay & Calcutta				22,00,000	
				<hr/>	
				1,67,00,000	
				<hr/>	
(3) Beds—9,000					
(Total number in all the above eight mental hospitals including 2 new ones).					
@ Rs. 1,000 per bed × 5 years				..	4,50,00,000
(4) Training of nurses in mental hospitals—2 years course—100 nurses to be admitted for training each year.					..
Total number of nurses that require stipends, etc., in first five years = 900.					
@ 75 per month, 900 × 75 × 12 months				..	8,10,000
(5) Training of Doctors in U.K.					
20 × 8,000 × 5 years				..	8,00,000
(6) Salaries of Central and Provincial Mental Officers—					
Centre				..	1,66,550
Provinces				..	8,80,550
Maintenance charges on capital works				..	10,02,000
Total (recurring)				..	<hr/>
					4,56,59,110
					<hr/>

### *Estimates of Expenditure on Mental Institutions.*

Second five years.

	Non-recurring. Rs.	Recurring. Rs.
(1) Improvements to the remaining mental hospitals—		
(a) Ahmedabad (500 = beds)	} @ Rs. 10,00,000 per hospital.  10,00,000 × 9 =	
(b) Ratnagiri (500 = beds)		
(c) Dharwar (500 = beds)		
(d) Calicut (500 = beds)		
(e) Waltair (500 = beds)		
(f) Barsilly (100 = beds)		
(g) Benares		
(h) Hyderabad (Sind)		
(i) Assam (1,000 = beds)		
	<hr/> 90,00,000 <hr/>	
(2) Opening of five new mental hospitals in Madras, Punjab, U. P., Bihar and Central Provinces, each with 500 beds @ Rs. 22 lakhs per hospital for building and equipment	1,10,00,000	
(3) Increasing the bed strength of the two new mental hospitals in Calcutta and Bombay, started in the first five years, from 200 to 500 beds	22,00,000	
Total non-recurring	<hr/> 2,22,00,000 <hr/>	
<b>Recurring—</b>		
(4) Total beds—(1st five years 9,000 + 18,000 2nd five years). 9,000		
@ Rs. 1,000 per bed per year for five years		9,00,00,000
(5) Training of nurses—50 nurses to be admitted each year for two years course. Each nurse gets Rs. 75 p.m. as stipend during training 50 × 75 × 12		4,95,000
(6) Training of doctors: 20 × 8,000 × 5		8,00,000
(7) Salaries of Central and Provincial Mental Officers attached to the respective health organisations.	} Centre .. } Provincial ..	1,73,460 10,32,350
(8) Maintenance charge on non-recurring expenditure		38,37,000
Total (recurring)		<hr/> 9,63,37,810 <hr/>
Grand Total (recurring) of the 1st ten years		14,49,96,920

*Mental Health Organisation.*

	1st year. Rs.	2nd year. Rs.	3rd year. Rs.	4th year. Rs.	5th year. Rs.	6th year. Rs.	7th year. Rs.	8th year. Rs.	9th year. Rs.	10th year. Rs.
<i>Provinces.</i>										
Provincial Mental Officer @ Rs. 600—40—1,000 plus 250 p.m. as special pay ..	7,209	7,680	8,160	8,640	9,120	9,600	10,080	10,560	11,040	11,520
Pension @ Rs. 98 p.m. ..	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
Leave salary ..	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176
Allowances ..	1,530	1,602	1,674	1,746	1,818	1,890	1,962	2,034	2,106	2,178
	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
<b>Total</b>	<b>14,906</b>	<b>15,458</b>	<b>16,010</b>	<b>16,562</b>	<b>17,114</b>	<b>17,666</b>	<b>18,218</b>	<b>18,770</b>	<b>19,322</b>	<b>19,874</b>
	1st five years.	Rs. 80,050								
For eleven Provinces ..	1st five years.	Rs. 80,050 × 11 = Rs. 880,550	1st ten years.	= Rs. 1,73,900.						
	Second five years.	Rs. 93,850 × 11 = Rs. 10,32,350.	1st ten years.	= Rs. 19,12,900.						

<i>Centre.</i>										
Mental Officer at the Centre @ Rs. 1,900—50—2,100.	22,800	23,400	24,000	24,600	25,200	25,020	25,200	25,200	25,200	25,200
Pension @ Rs. 176 p.m. ..	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112
Leave salary @ 15 p.c. ..	3,420	3,510	3,600	3,690	3,780	3,780	3,780	3,780	3,780	3,780
Allowances ..	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600
<b>Total</b>	<b>31,932</b>	<b>32,622</b>	<b>33,312</b>	<b>34,002</b>	<b>34,692</b>	<b>34,692</b>	<b>34,692</b>	<b>34,692</b>	<b>34,692</b>	<b>34,692</b>
	1st five years.	Rs. 1,66,560.								
	1st ten years.	Rs. 3,40,020.	Second five years.	Rs. 1,73,460						



## RECURRING

*Provincial Venereal Diseases Organisation and its expenditure.*

1st. five years.

Ten years.

## DETAILS OF EXPENDITURE.

## 1. Provincial organisation.—

	Rs.	Rs.	Rs.
1st year ..	1,80,696		
2nd year ..	1,83,898		
3rd year ..	1,87,081		
4th year ..	1,90,273		
5th year ..	1,93,446	$9,35,394 \times 11 = 1,02,89,334$	..
6th year ..	1,97,108		
7th year ..	2,00,317		
8th year ..	2,03,948		
9th year ..	2,06,738		
10th year ..	2,08,949	$19,53,454 \times 11 =$	2,14,87,994

## 2. District organisation.—

1st year ..	13,497		
2nd year ..	14,039		
3rd year ..	14,582		
4th year ..	15,125		
5th year ..	15,668	$72,911 \times 216 = 1,57,48,776.$	..
6th year ..	16,382		
7th year ..	16,934		
8th year ..	17,486		
9th year ..	18,037		
10th year ..	18,589	$1,60,328 \times 216 =$	3,46,33,096

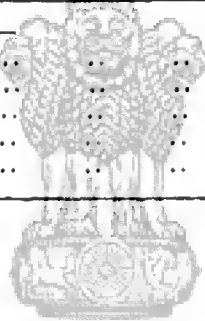
## 3. Purchase of Drugs.—

1st year ..	4,000		
2nd year ..	4,000		
3rd year ..	4,000		
4th year ..	6,000		
5th year ..	8,000	$26,000 \times 216 = 56,16,000.$	..
6th year ..	10,400		
7th year ..	12,800		
8th year ..	15,200		
9th year ..	18,400		
10th year ..	21,600	$1,04,400 \times 216 =$	2,25,50,496

Total ..	..	<u>3,16,54,110</u>	<u>7,86,71,402</u>
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*Provincial Venereal diseases organisation and its expenditures.***STAFF :—**

Name.	No.	Scale of pay.
<b>Provincial Organisation.—</b>		
Officer in charge .. .. .	1	Rs. 600—40—1,000.
Assistant Officer in charge .. .. .	2	Rs. 500—30—800.
Propaganda officer .. .. .	1	Rs. 350—25—500.
Social workers supervisor. .. .. .	1	Rs. 250—25—500.
Propaganda workers .. .. .	8	Rs. 100—5—150.
Clerks .. .. .	3	Rs. 100—5—200.
Accountant .. .. .	1	Rs. 150—5—250.
Stenographers .. .. .	2	Rs. 100—5—200.
Inferior servants .. .. .	2	Rs. 25—2—55.
<b>2. District clinic organisation.—</b>		
Medical officer .. .. .	1	Rs. 250—25—500.
Social worker .. .. .	1	Rs. 125—5—150.
Clerk .. .. .	1	Rs. 100—5—200.
Inferior servant .. .. .	1	Rs. 25—2—55.
Sweeper .. .. .	1	Rs. 25—1—35.

**3. Provision for purchase of drugs.—**

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**VENEREAL DISEASES—contd.**  
*Provincial Organisation (further details).*

Number.	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
Officer In-charge @ Rs. 600—40—1,000.	1	7,200	7,680	8,160	8,640	9,120	9,600	10,080	10,560	11,040
Assistant Officer in-charge @ Rs. 500—30—800.	2	12,000	12,720	13,440	14,160	14,880	15,600	16,320	17,040	17,760
Propaganda Officer @ Rs. 350—25—500.	1	4,200	4,500	4,800	5,100	5,400	5,700	6,000	6,300	6,600
Social Worker Supervisor @ Rs. 250—25—500.	1	3,000	3,300	3,600	3,900	4,200	4,500	4,800	5,100	5,400
Propaganda Workers @ Rs. 100—5—150.	8	9,600	10,080	10,560	11,040	11,520	12,000	12,480	12,960	13,440
Clerks .. .. @ Rs. 100—5—200.	3	3,600	3,780	3,960	4,140	4,320	4,500	4,680	4,860	5,040
Accountant @ Rs. 150—5—250.	1	1,800	1,860	1,920	1,980	2,040	2,100	2,160	2,220	2,280
Stenographers .. @ Rs. 100—5—200.	2	2,400	2,520	2,640	2,760	2,880	3,000	3,120	3,240	3,360
Inferior servants @ Rs. 25—2—55.	2	600	648	696	744	792	840	888	936	984
Propaganda and publicity Rs. 10,000 p.m.		1,20,000	1,20,000	1,20,000	1,20,000	1,20,000	1,20,000	1,20,000	1,20,000	1,20,000
Travelling allowance		3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
Contingencies ..		10,296	10,810	11,305	11,809	12,314	12,818	13,323	13,827	14,332
Pension & leave charges ..										
<b>Total Rs.</b>	..	1,80,696	1,83,898	1,87,081	1,90,273	1,93,466	1,97,108	2,00,317	2,03,948	2,08,949

*VENEREAL DISEASES—contd.  
District Clinic (further details).*

	Number.	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
		Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
Medical Officer ..	1	3,000	3,300	3,600	3,900	4,200	4,500	4,800	5,100	5,400	5,700
@ Rs. 250—25—500.											
Social Worker ..	1	1,500	1,560	1,620	1,680	1,740	1,800	1,860	1,920	1,980	2,140
@ Rs. 125—5—150.											
Clerk ..	1	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740
@ Rs. 100—5—200.											
Inferior servant ..	1	360	324	348	372	396	420	444	468	492	516
@ Rs. 25—2—55.											
Sweeper ..	1	300	312	324	336	348	360	372	384	396	408
@ Rs. 25—1—35.											
Contingencies ..		6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000
@ Rs. 6,000 a year.											
Pension & leave salary charges ..		1,197	1,283	1,370	1,457	1,544	1,802	1,898	1,993	2,089	2,185
<b>Total Rs. ..</b>		<b>13,497</b>	<b>14,039</b>	<b>14,582</b>	<b>15,125</b>	<b>15,668</b>	<b>16,382</b>	<b>16,934</b>	<b>17,485</b>	<b>18,037</b>	<b>18,589</b>

*Estimate of expenditure on Leprosy organisations.*

## LEPROSY (CENTRE).

Central Leprosy Institute.

1st five years. 1st ten years.

	Rs.	Rs.
Non-recurring expenditure .. .. .	5,00,000	5,00,000

*Recurring :*

Maintenance @ 3 p.c. per year on the above non-recurring cost .. .. .	30,000	1,05,000
*Annual recurring cost including salaries of staff, etc. .. .. .	4,30,386	9,39,462
Total (Recurring) .. .. .	4,60,386	10,44,462

\*Annual recurring cost from year to year :

	Rs.	1st 5 years. Rs.	1st ten years. Rs.
1st year .. .. .	79,782		
2nd year .. .. .	82,930		
3rd year .. .. .	86,077		
4th year .. .. .	89,223		
5th year .. .. .	92,372	4,30,386	
6th year .. .. .	95,520		
7th year .. .. .	98,663		
8th year .. .. .	1,01,815		
9th year .. .. .	1,04,963		
10th year .. .. .	1,08,116		9,39,462

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*Salaries of Staff of the Central Leprosy Institute (further details).*

	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
Chief .. 1 .. ..	15,000	15,600	16,200	16,800	17,400	18,000	18,600	19,200	19,800	20,400
@ 1,250-50-1,750.										
Senior Assistants-2 .. ..	19,200	20,160	21,120	22,080	23,040	24,000	24,960	25,920	26,880	27,840
@ Rs. 800-40-1,200										
Junior Assistants 2 .. ..	14,400	15,120	15,840	16,560	17,280	18,000	18,720	19,440	20,160	20,880
@ Rs. 600-30-900										
Social worker .. 1 .. ..	4,500	4,800	5,100	5,400	5,700	6,000	6,300	6,600	6,900	7,200
@ Rs. 375-25-750.										
Other staff including ministerial staff and including contingencies @ Rs.15,000 per year. .. ..	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000
Pension & leave salary charges .. ..	11,632	12,250	12,817	13,385	13,952	14,520	15,088	15,655	16,223	16,790
<b>Total Rs. ..</b>	<b>79,782</b>	<b>82,930</b>	<b>86,077</b>	<b>89,225</b>	<b>92,372</b>	<b>95,520</b>	<b>98,668</b>	<b>1,01,815</b>	<b>1,04,963</b>	<b>1,08,116</b>

## Leprosy (contd.)

## Province :

Non-recurring.	1st five years. Rs.	1st ten years. Rs.
I. Increasing the existing bed provision by 14,000 beds for institutional treatment, in the first five years @ Rs. 1,000 per bed per year .. .. .	1,40,00,000	..
Adding a similar provision during the second five years .. .. .	..	2,80,00,000
Total (non-recurring) ..	1,40,00,000	2,80,00,000

(N.B.—Working details are given below, item by item.)

## II. Recurring.

Maintenance @ 3 p.c. per year on the above non-recurring expenditure, assuming the same annual increase in the number of beds .. .. .	8,40,000	37,80,000
(b) Annual recurring cost for maintaining from year to year the above mentioned beds @ Rs. 400 per bed per year .. .. .	1,68,00,000	6,16,00,000
(c) Cost of Provincial Leprosy Organisation, after reduction of the total by one-third, to conform more correctly to differing provincial requirements.	24,94,646	55,79,926
(d) Propaganda and Publicity @ Rs. 5,000 per province per year .. .. .	2,75,000	5,50,000
(e) Financial help to voluntary organisations @ Rs. 125 per bed per year, for 10,000 beds during the first five years .. .. .	62,50,000	..
Adding a similar provision during the second five years .. .. .	..	1,87,50,000
(f) Development of Group Isolation Colonies @ Rs. 3 lakhs per year .. .. .	15,00,000	30,00,000
Total (recurring) ..	2,81,59,646	9,32,59,926

(a) It is assumed that the increase of 14,000 beds is affected evenly over the first five years, or 2,800 beds are added every year. A similar annual provision will be added during the second five-year period also.

MAINTENANCE @ 3 p.c. p. a.			
		1st five years.	1st ten years.
1st year's capital expenditure Rs. 28,00,000 .. .. .	..	3,36,000	7,56,000
2nd year's capital expenditure Rs. 28,00,000 .. .. .	..	2,52,000	6,72,000
3rd year's capital expenditure Rs. 28,00,000 .. .. .	..	1,68,000	5,88,000
4th year's capital expenditure Rs. 28,00,000 .. .. .	..	84,000	5,04,000
5th year's capital expenditure Rs. 28,00,000 .. .. .	..	..	4,20,000
		8,40,000	
6th year's capital expenditure Rs. 28,00,000 .. .. .	..	..	3,36,000
7th year's capital expenditure Rs. 28,00,000 .. .. .	..	..	2,52,000
8th year's capital expenditure Rs. 28,00,000 .. .. .	..	..	1,68,000
9th year's capital expenditure Rs. 28,00,000 .. .. .	..	..	84,000
10th year's capital expenditure Rs. 28,00,000 .. .. .	..	..	..
			37,80,000

Leprosy (*contd.*).

(b)				New beds.	Total beds.	Total maintenance.
						Rs.
1st year	2,800	..	..	..	2,800	11,20,000
2nd year	2,800	..	..	..	5,600	22,40,000
3rd year	2,800	..	..	..	8,400	33,60,000
4th year	2,800	..	..	..	11,200	44 80,000
5th year	2,800	..	..	..	14,000	56,00,000
						Rs.
6th year	2,800	..	..	..	16,800	67,20,000
7th year	2,800	..	..	..	19,600	78,40,000
8th year	2,800	..	..	..	22,400	89,60,000
9th year	2,800	..	..	..	25,200	1,00,80,000
10th year	2,800	..	..	..	28,000	1,12,00,000
						Rs.
						1,68,00,000

(c) Details of annual expenditure on Provincial Leprosy Organisations.  
(Please see next page also).

				Rs.
1st year	..	..	..	62,333
2nd year	..	..	..	65,553
3rd year	..	..	..	67,554
4th year	..	..	..	70,764
5th year	..	..	..	73,975
				3,40,179 × 11 × 2 3
				= 24,94,646
6th year	..	..	..	77,644
7th year	..	..	..	80,871
8th year	..	..	..	84,320
9th year	..	..	..	87,328
10th year	..	..	..	90,557
				7,60,899 × 11 × 2 3
				= 55,79,926
(d) 5,000 × 11 × 5 = 2,75,000 1st five years.				3
1st ten years 2,75,000 + 2,75,000 =				5,50,000
(e) 1st five years = 10,000 × 125 × 5 = 62,50,000				
2nd five years = 20,000 × 125 × 5 = 1,25,00,000				
Total ten years .. 1,25,00,000 + 62,50,000 =				1,87,50,000
(f) 1st five years .. 3,00,000 × 5 = 15,00,000				
Ten years .. 15,00,000 + 15,00,000 =				30,00,000



*Leprosy (contd.) (Further details.)*  
(Provincial Organisation).

	Number.	1st year.		2nd year.		3rd year.		4th year.		5th year.		6th year.		7th year.		8th year.		9th year.		10th year.	
		Rs.	Ra.	Rs.	Ra.	Rs.	Ra.	Rs.	Ra.	Rs.	Ra.	Rs.	Ra.	Rs.	Ra.	Rs.	Ra.	Rs.	Ra.	Rs.	Ra.
Officer in charge	1	7,200	7,680	8,160	8,640	9,120	9,600	10,080	10,560	11,040	11,520	11,520	11,520	11,520	11,520	11,520	11,520	11,520	11,520	11,520	11,520
@ Rs. 600-40-1,000.																					
Assistant Officer in charge	2	12,000	12,700	13,440	14,160	14,880	15,600	16,320	17,040	17,760	18,480	18,480	18,480	18,480	18,480	18,480	18,480	18,480	18,480	18,480	18,480
@ Rs. 500-30-800.																					
Propaganda Officer	1	4,200	4,500	4,800	5,100	5,400	5,700	6,000	6,300	6,600	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900
@ Rs. 350-25-500.																					
Social Worker Supervisor	1	3,000	3,300	3,600	3,900	4,200	4,500	4,800	5,100	5,400	5,700	5,700	5,700	5,700	5,700	5,700	5,700	5,700	5,700	5,700	5,700
@ Rs. 250-25-500.																					
Propaganda Workers	8	9,600	10,080	10,560	11,040	11,520	12,000	12,480	12,960	13,440	13,920	13,920	13,920	13,920	13,920	13,920	13,920	13,920	13,920	13,920	13,920
@ Rs. 100-5-150.																					
Clerks ..	3	3,600	3,780	3,960	4,140	4,320	4,500	4,680	4,860	5,040	5,220	5,220	5,220	5,220	5,220	5,220	5,220	5,220	5,220	5,220	5,220
@ Rs. 100-5-200.																					
Accountant ..	1	1,800	1,860	1,920	1,980	2,040	2,100	2,160	2,220	2,280	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340
@ Rs. 150-5-250.																					
Stenographers ..	2	2,400	2,520	2,640	2,760	2,880	3,000	3,120	3,240	3,360	3,480	3,480	3,480	3,480	3,480	3,480	3,480	3,480	3,480	3,480	3,480
@ Rs. 100-5-200.																					
Inferior Servants	2	600	648	696	744	792	840	888	936	984	1,032	1,032	1,032	1,032	1,032	1,032	1,032	1,032	1,032	1,032	1,032
@ Rs. 25-2-55.																					
Travelling allowance	..	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
Contingencies ..	..	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
Pension & leave salary charges	..	10,296	10,810	11,305	11,809	12,314	13,268	13,769	14,524	14,834	15,357	15,357	15,357	15,357	15,357	15,357	15,357	15,357	15,357	15,357	15,357
Total Rs.	..	62,333	65,553	67,554	70,764	73,975	77,644	80,871	84,320	87,328	90,557	90,557	90,557	90,557	90,557	90,557	90,557	90,557	90,557	90,557	90,557

## SCHOOL HEALTH.

1st five years.

## Non-recurring :

For one province .. .. .	Rs. 12,000
For eleven provinces .. .. .	$12,000 \times 11 = 1,32,000$

## Recurring :

Maintenance at 3 p.c. per year on the non-recurring expenditure .. .. .	7,920	Rs.
*Salaries of staff for one province for five years	1,71,610	
„ for eleven provinces .. .. .	18,87,710	
	7,920	
	<u>18,95,630</u>	

\*Salaries of staff.

	1st five years	1st ten years.
	Rs.	Rs.
1st year	31,324	
2nd „	32,823	
3rd „	34,322	
4th „	35,821	
5th „	37,320	
6th „	38,818	
7th „	40,319	
8th „	41,821	
9th „	43,323	
10th „	44,825	
	$1,71,610 \times 11 = 18,87,710$	$3,81,067 \times 11 =$
Total recurring—ten years .. .. .		41,91,737
		<u>27,720</u>
		42,19,457

## Ten years,

No additional capital expenditure.

	Rs.
Non-recurring .. .. .	1,32,000
Recurring .. .. .	81,43,993
Maintenance .. .. .	<u>27,720</u>

SCHOOL MEDICAL SERVICE.  
(Further details).

Number.	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
Officer in Charge @ Rs. 400—40—1,000 ..	7,200	7,680	8,160	8,640	9,120	9,600	10,080	10,560	11,040	11,520
Assistant officer in Charge @ Rs. 500—30—800 ..	6,000	6,360	6,720	7,080	7,440	7,800	8,160	8,520	8,880	9,240
Nurse Supervisor @ Rs. 250—25—500 ..	3,000	3,300	3,600	3,900	4,200	4,500	4,800	5,100	5,400	5,700
Clerk @ Rs. 100—5—200 ..	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740
Stenographer @ Rs. 100—5—200 ..	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740
Inferior servant Rs. 25—2—55 ..	300	324	348	372	396	420	444	468	492	516
Travelling allowance ..	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500
Contingencies ..	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500
Pension & Leave charges ..	5,424	5,639	5,854	6,069	6,284	6,568	6,786	7,003	7,221	7,439
Total Rs.	31,324	32,823	34,322	35,821	37,320	38,898	40,390	41,891	43,393	44,895

## NURTION.

*1st five years.**Non-recurring :*

Rs. 55,000 for one Province				Rs.
For the eleven Provinces ..	..	..	$55,000 \times 11 =$	6,05,000
Maintenance at 3 p.a. per year ..	..	..	..	36,300

*Recurring :*

*Salaries of staff				
For one province for five years	3,09,166	..	..	..
For eleven provinces ..	..	..	..	..
				34,00,826
				36,300
				<u>34,37,126</u>

*\*Salaries of staff**1st five years.**1st ten years.*

	Rs.		Rs.
1st year	$39,028 + 10,440 + 6,890 = 56,358$		
2nd ..	$40,499 + 11,233 + 7,364 = 59,096$		
3rd ..	$41,969 + 12,027 + 7,837 = 61,833$		
4th ..	$43,440 + 12,820 + 8,310 = 64,570$		
5th ..	$44,911 + 13,614 + 8,784 = 67,309$	$3,09,166 \times 11$	
		$= 34,00,826$	
6th ..	$46,695 + 14,656 + 9,416 = 70,767$		
7th ..	$48,181 + 15,463 + 9,898 = 73,542$		
8th ..	$49,668 + 16,270 + 10,379 = 76,317$		
9th ..	$51,154 + 17,077 + 10,861 = 79,092$	$6,90,751 \times 11$	
10th ..	$52,641 + 17,884 + 11,341 = 81,866$		75,98,261

*Second five years.*

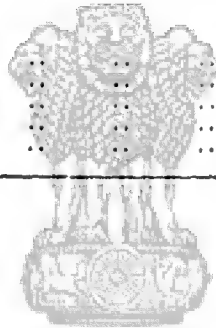
Non-Recurring—Nothing additional:

Total for ten years—				
Non-recurring ..	..	..	6,05,000	
Recurring ..	..	..	75,98,261	} 77,25,311
Maintenance ..	..	..	1,27,050	

## SHORT-TERM PROVINCIAL NUTRITION STAFF.

*Further details.*

Name.				No.	Scale of pay.
<b>Staff :—</b>					
Chief Nutrition Officer	..	..	..	1	Rs. 600—40—1,000
<b>Field :—</b>					
Field workers	..	..	..	3	Rs. 300—20—500
Inferior servants	..	..	..	3	Rs. 25—2—55
<b>Laboratory :—</b>					
Chief Assistant (Chemistry & Biochemistry)	..	..	..	1	Rs. 300—20—500
Chemist	..	..	..	1	Rs. 150—10—250
Laboratory Assistants	..	..	..	3	Rs. 50—5—100
Animal Attendants	..	..	..	8	Rs. 25—2—55
Inferior servants	..	..	..	2	Rs. 25—2—55
<b>Office :—</b>					
Stenographer	..	..	..	1	Rs. 75—5—150
Typist clerks	..	..	..	2	Rs. 60—5—100
Statistician	..	..	..	1	Rs. 150—10—250
Artist	..	..	..	1	Rs. 100—5—150
Inferior servants	..	..	..	2	Rs. 25—2—55



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# Short-term Provincial Nutrition Staff.

Further details.

	Number.	1st year.	2nd year.	3rd year.	4th year.	5th year.	6th year.	7th year.	8th year.	9th year.	10th year.
		Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
<b>Staff</b>											
Chief Nutrition Officer @ Rs. 600—40—1,000	1	7,200	7,680	8,160	8,640	9,120	9,600	10,080	10,560	11,040	11,520
<b>Field.</b>											
Field workers @ Rs. 300—20—500	3	10,800	11,520	12,240	12,960	13,680	14,400	15,120	15,840	16,560	17,280
Inferior servants @ Rs. 25—2—55	3	900	972	1,044	1,116	1,188	1,260	1,332	1,404	1,476	1,548
Recurring expenditure on chemicals, travelling and miscellaneous	..	..	..	..	..	..	..	..	..	..	..
Pension & Leave salary	..	..	..	..	..	..	..	..	..	..	..
Total Rs.	..	39,028	40,488	41,968	43,440	44,911	46,385	47,859	49,333	50,807	52,281
<b>Laboratory.</b>											
Chief Assistant @ Rs. 300—20—500	1	3,600	3,840	4,080	4,320	4,560	4,800	5,040	5,280	5,520	5,760
Chemist @ Rs. 160—10—260	1	1,800	1,920	2,040	2,160	2,280	2,400	2,520	2,640	2,760	2,880
Laboratory Assistants @ Rs. 50—5—100	3	1,800	1,980	2,160	2,340	2,520	2,700	2,880	3,060	3,240	3,420
Animal attendants @ Rs. 25—2—55	3	900	972	1,044	1,116	1,188	1,260	1,332	1,404	1,476	1,548
Inferior Servants @ Rs. 25—2—55	3	900	972	1,044	1,116	1,188	1,260	1,332	1,404	1,476	1,548
Pension & leave salary	..	..	..	..	..	..	..	..	..	..	..
Total Rs.	..	10,440	11,233	12,027	12,820	13,614	14,408	15,202	16,000	16,794	17,588

## NUVARTON.

(Further details—contd.)

	Number.	1st year.		2nd year.		3rd year.		4th year.		5th year.		6th year.		7th year.		8th year.		9th year.		10th year.	
		Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.	Rs.
Office.																					
Stenographer @ Rs. 75-5-150 ..	1	900	960	1,020	1,080	1,140	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740	1,800	1,860	1,920	1,980	2,040
Typist clerks @ Rs. 60-5-100 ..	2	1,440	1,560	1,680	1,800	1,920	2,040	2,160	2,280	2,400	2,520	2,640	2,760	2,880	3,000	3,120	3,240	3,360	3,480	3,600	3,720
Statistician @ Rs. 150-10-250 ..	1	18,00	19,20	20,40	21,60	22,80	24,00	25,20	26,40	27,60	28,80	30,00	31,20	32,40	33,60	34,80	36,00	37,20	38,40	39,60	40,80
Artist @ Rs. 100-5-150 ..	1	1,200	1,260	1,320	1,380	1,440	1,500	1,560	1,620	1,680	1,740	1,800	1,860	1,920	1,980	2,040	2,100	2,160	2,220	2,280	2,340
Inferior Servants @ Rs. 25-2-55	2	600	648	696	744	792	840	888	936	984	1,032	1,080	1,128	1,176	1,224	1,272	1,320	1,368	1,416	1,464	1,512
Pension and Leave salary	..	950	1,016	1,081	1,146	1,212	1,278	1,344	1,410	1,476	1,542	1,608	1,674	1,740	1,806	1,872	1,938	2,004	2,070	2,136	2,202
Total Rs.	..	6,890	7,364	7,837	8,310	8,784	9,257	9,730	10,203	10,676	11,149	11,622	12,095	12,568	13,041	13,514	13,987	14,460	14,933	15,406	15,879

## PROFESSIONAL EDUCATION.

*Estimates of non-recurring expenditure during the first five years.*

	Rs.	Rs.
Professional Education—		
(a) (i) Upgrading (9) at Rs. 27·0 lakhs per college	2,43,00,000	
Conversion (8) at Rs. 77·0 lakhs per college .. .. .	6,16,00,000	
Creation (7) at Rs. 102·0 lakhs per college .. .. .	7,14,00,000	15,73,00,000
(ii) Accommodation for personnel under training ; 24 to each of the 15 primary units attached to a medical college for 24 colleges .. .. .		1,08,00,000
(b) Dental Education—		
(i) 2 new colleges at Rs. 25 lakhs per college	50,00,000	
(ii) Improving the Lahore College .. .. .	10,00,000	60,00,000
(c) Pharmaceutical Education—		
(i) 50 teaching centres for Licentiate course at Rs. 10,000 per centre .. .. .	5,00,000	
(ii) 5 colleges for graduate course at Rs. 25,000 per college .. .. .	1,25,000	6,25,000
(d) Public Health Engineering at Rs. 2 lakhs per centre .. .. .		6,00,000
(e) Nursing—		
(i) 16 Preliminary centres at Rs. 1·25 lakhs per centre .. .. .	20,00,000	
(ii) 100 Centres for training of Nurse pupils	3,00,00,000	
(iii) For training 4,000 midwives each year	1,00,00,000	4,20,00,000
(f) Improvement to 48 associated hospitals attached to 24 colleges at Rs. 1 lakh per college .. .. .		48,00,000
(g) Medical Research in Colleges at Rs. 1 lakh per college for 24 colleges .. .. .		24,00,000
(h) Hospital Social Workers .. .. .		
Total .. .. .		22,45,25,000



## PROFESSIONAL EDUCATION.

*Estimates of non-recurring expenditure during second five years and during the first ten years.*

	Second five years. Rs.	Total ten years. Rs.
Professional Education—		
(a) (i) Upgrading (7) at Rs. 27.0 lakhs per college .. .. .	1,89,00,000	
Conversion (3) at Rs. 77.0 lakhs per college .. .. .	2,31,00,000	
Creation (9) at Rs. 102.0 lakhs per college .. .. .	9,18,00,000	
	<u>13,38,00,000</u>	<u>29,11,00,000</u>
(ii) Accommodation for personnel under training 24 to each of the 15 primary units attached to a medical college for 19 colleges	85,50,000	1,93,50,000
(b) Dental Education—		
Three new colleges at Rs. 25 lakhs per college	75,00,000	1,55,00,000
(c) Pharmaceutical Education—		
(i) 50 teaching centres for Licentiate course at Rs. 10,000 per centre .. .. .	5,00,000	
(ii) 5 colleges for graduates course at Rs. 25,000 per college .. .. .	1,25,000	6,25,000
		<u>12,50,000</u>
(d) Public Health Engineering—		
Two new centres at Rs. 2 lakhs each .. .. .	4,00,000	10,00,000
(e) Nursing—		
(i) 16 preliminary centres at Rs. 1.25 lakhs per centre .. .. .	20,00,000	
(ii) 100 Centres for pupil nurses .. .. .	3,00,00,000	
(iii) For training 4,000 midwives at Rs. 25,000 for each .. .. .	1,00,00,000	
	<u>4,20,00,000</u>	<u>8,40,00,000</u>
(f) 38 Associated hospitals to 19 colleges at one lakh per hospital .. .. .	38,00,000	86,00,000
(g) Medical Research in 19 colleges at Rs. one lakh per college .. .. .	19,00,000	43,00,000
(h) Hospital Social Workers .. .. .	..	..
Total .. .. .	<u>19,85,75,000</u>	<u>42,31,00,000</u>

*Cost of accommodation for personnel under training in primary units attached to Medical Colleges.*

Floor space area.		Cost per sq. ft.	Total cost.
For one	For 24		
250 sq. ft.	6,000 sq. ft.	Rs. 5	Rs. 30,000
One college .. .. .	.. .. .	= Rs. 30,000 × 15 =	4,50,000
1st five years for 24 colleges .. .. .	.. .. .	= Rs. 24 × 4,50,000 =	1,08,00,000
2nd five years for 19 colleges .. .. .	.. .. .	= Rs. 19 × 4,50,000 =	85,50,000

## PROFESSIONAL EDUCATION.

*Estimates of recurring expenditure for the first five years.*

	Rs.	Rs.
(1) Professional Education—		
(a) Upgrading (9 colleges) at Rs. 8.25 lakhs per year per college .. .. .	3,71,25,000	
Conversion (8 colleges) at Rs. 17.25 lakhs per year per college .. .. .	6,90,00,000	
Creation (7 colleges) at Rs. 17.25 lakhs per year per college .. .. .	6,03,75,000	
		16,65,00,000
(b) Dental Education—		
(i) Two new colleges at Rs. 5 lakhs per college per year .. .. .	50,00,000	
(ii) Improving the Lahore College at Rs. 5 lakhs per year .. .. .	25,00,000	
		75,00,000
(c) Pharmaceutical Education—		
(i) 50 teaching centres for Licentiate course at Rs. 6,000 per centre per year ..	15,00,000	
(ii) 5 colleges for graduate course at Rs. 10,000 per college per year ..	2,50,000	
(iii) Provincial Pharmaceutical Council at Rs. 10,000 per province per year ..	5,50,000	
		23,00,000
(d) Public Health Engineering. 3 training centres at Rs. 50,000 per year per centre		7,50,000
(e) Provincial Sanitary Boards at Rs. 5,000 per year per board (one board for each province)		2,75,000
(f) Nursing—		
(i) 18 preliminary training centres at Rs. 50,000 per centre per year ..	40,00,000	
(ii) 100 centres for training of pupil nurses at Rs. 1.5 crores per year .. .. .	7,50,00,000	
(iii) Training of 4,000 midwives each year at Rs. 49 lakhs per year .. .. .	2,45,00,000	
(iv) Refresher courses at Rs. 0.45 lakhs per year .. .. .	2,25,000	
(v) Text books at Rs. 0.25 lakh per year ..	1,25,000	
		10,38,50,000
(g) Health Assistants .. .. .		31,68,000
(h) Hospital Social Workers .. .. .		5,78,420
(i) Foreign scholarships at Rs. 3 lakh per year		15,00,000
(j) Improvements to 48 associated hospitals for the training of interneers (24 colleges) at Rs. 10,000 per hospital per year ..		24,00,000
(k) Five institutions for postgraduate medical education at Rs. 50,000 per centre per year .. .. .		12,50,000
(l) Medical research in colleges (24 colleges) at Rs. 0.25 lakh per year per college ..		30,00,000
(m) Scholarships at Rs. 1,000 per year per student for 50 p.c. of the total number of admissions during the first five years ..		1,34,40,000

## PROFESSIONAL EDUCATION.

*Estimates of recurring expenditure for the second five years and first ten years.*

	Second five years. Rs.	First ten years. Rs.
(a) (i) Upgrading (7 colleges) at Rs. 8.25 lakhs per college per year .. .. .	2,88,75,000	
(ii) Conversion (3 colleges) at Rs. 17.25 lakhs per college per year .. .. .	2,58,75,000	
(iii) Creation (9 colleges) at Rs. 17.25 lakhs per college per year .. .. .	7,76,25,000	
	<hr/>	29,88,75,000
	13,23,75,000	
(b) Dental Education— Three new colleges at Rs. 5 lakhs per college per year .. .. .	75,00,000	1,50,00,000
(c) Pharmaceutical Education— (i) 50 teaching centres for Licentiate's course at Rs. 6,000 per centre per year .. .. .	15,00,000	
(ii) Five colleges for graduate course at Rs. 10,000 per college per year .. .. .	2,50,000	
(iii) Provincial Pharmaceutical Council at Rs. 10,000 per province per year .. .. .	5,50,000	
	<hr/>	48,00,000
	23,00,000	
(d) Public Health Engineering— Two training centres at Rs. 50,000 per centre per year .. .. .	5,00,000	12,50,000
(e) Provincial Sanitary Boards at Rs. 5,000 per board per year .. .. .	2,75,000	6,50,000
(f) Nursing— (i) The remaining 16 preliminary training centres at Rs. 50,000 per centre per year .. .. .	40,00,000	
(ii) 100 centres for training pupil nurses at Rs. 1.5 crores per year for all of them .. .. .	7,50,00,000	
(iii) Training of 4,000 midwives at Rs. 49 lakhs per year .. .. .	2,45,00,000	
(iv) Refresher courses at Rs. 0.45 lakh per year .. .. .	2,25,000	
(v) Text books at Rs. 0.25 lakh per year .. .. .	1,25,000	
	<hr/>	10,38,50,000
	20,77,00,000	
(g) Health Assistants .. .. .	31,68,000	63,36,000
(h) Hospital social workers .. .. .	..	..
(i) Foreign scholarships at Rs. 3 lakhs per year .. .. .	15,00,000	30,00,000
(j) 38 Associated hospitals for the training of inter-nues at Rs. 10,000 per year, per hospital .. .. .	19,00,000	43,00,000
(k) Remaining five institutions for post-graduate medical education at Rs. 50,000 per centre per year .. .. .	12,50,000	25,00,000
(l) Medical research in 19 colleges at Rs. 0.25 lakh per college per year .. .. .	23,75,000	63,75,000
(m) Scholarships at Rs. 1,000 per year per student for 50 p.c. of the total number of admissions .. .. .	4,98,00,000	6,32,40,000

Maintenance  
at 3 p. o. per year.

(1) *Professional Education :—*

Rs.

*1st five years.—*

Total capital expenditure during the first five years is ..	22,45,25,000
We assume that one fifth of this amount will be spent each year ..	$22,45,25,000 \times 3 \times 1 \times 10$
Maintenance at 3% per year will be ..	$\frac{22,45,25,000 \times 3 \times 1 \times 10}{5 \times 5 \times 100 \times 1} = 1,34,71,500$

*2nd five years.—*

New capital expenditure on all the schemes connected with Professional Education is .. .. .	19,85,75,000
Maintenance on this amount will be calculated on the same basis as on the capital expenditure during the first five years—	$10 \times 19,85,75,000 \times 3$
	$\frac{10 \times 19,85,75,000 \times 3}{1 \times 5 \times 100} = 1,19,14,500$

Calculation of maintenance on those organisations which had come into being during the first five years will, however, be calculated for all the five years at 3 per cent. per annum in the second five year period—

	$22,45,25,000 \times 3 \times 5$	$= 3,36,78,750$
	$100 \times 5$	
Total maintenance charges for the second five years .. .. .	3,36,78,750	1,19,14,500
		<u>4,55,93,250</u>
Maintenance charges for the first ten years .. .. .	4,55,93,250	1,34,71,500
		<u>5,90,64,750</u>

सत्यमेव जयते

*First five years: Expenditure of Medical Colleges.*

	Improvement.		Conventions.		New Colleges.	
	Recurring. (Rs. in lakhs)	Non-recurring. (Rs. in lakhs)	Recurring. (Rs. in lakhs)	Non-recurring. (Rs. in lakhs)	Recurring. (Rs. in lakhs)	Non-recurring. (Rs. in lakhs)
Madras ..	(2) 12+4.5*	50+4.0*	(1) 15+2.25*	75+2.0*	(2) 30+4.50*	200+4.0*
Bombay ..	(1) 6+2.25*	25+2.0*	(1) 15+2.25*	75+2.0*	(1) 15+2.25*	100+2.0*
Central Provinces ..	..	..	(1) 15+2.25*	75+2.0*	..	..
Orissa ..	..	..	(1) 15+2.25*	75+2.0*	..	..
Bengal ..	(1) 6+2.25*	25+2.0*	(2) 30+4.50*	150+4.0*	(1) 15+2.25*	100+2.0*
Bihar ..	(1) 6+2.25*	25+2.0*	(1) 15+2.25*	75+2.0*	..	..
United Provinces ..	(1) 6+2.25*	25+2.0*	(1) 15+2.25*	75+2.0*	(2) 30+4.50*	200+4.0*
Punjab ..	(2) 12+4.50*	50+4.0*	(1) 15+2.25*	75+2.0*	(1) 15+2.25*	100+2.0*
Sind ..	..	..	..	..	..	..
Delhi ..	(1) 6+2.25*	25+2.0*	(1) 15+2.25*	75+2.0*	(1) 15+2.25*	100+2.0*
	54+20.25	225+18.0	(8) 120+18.00	600+16.0	(7) 105+15.75	700+14.0
	Expenditure.					
	Recurring. (Rs. in lakhs)	Non-recurring. (Rs. in lakhs)				
Total—	(9) 54+20.25	225+18.0				
Improvement ..	(8) 120+18.00	600+16.0				
Conversion ..	(7) 105+15.75	700+14.0				
Creation ..	279+54	1525+48.0				
	333	1573				

\*Recurring and Non-recurring expenditure in connection with a Department of Preventive & Social Medicine.

It has been assumed that the improvement of colleges so as to admit 120 students each year, will be completed during the first year as well as the conversion of schools into colleges and that the newly created colleges will begin to function from the third year.

*Second five years:—Expansion of Medical Colleges.*

	Improvement.		Conversion.		New Colleges.	
	Recurring. Rs. (in lakhs)	Non-recurring. Rs. (in lakhs)	Recurring. Rs. (in lakhs)	Non-recurring. Rs. (in lakhs)	Recurring. Rs. (in lakhs)	Non-recurring. Rs. (in lakhs)
Madras ..	(2) 12+4.50*	50+4.0*	..	..	(3) 45+6.75*	300+6.0*
Bombay ..	(1) 6+2.25*	25+2.0*	..	..	(1) 15+2.25*	100+2.0*
Central Provinces ..	..	..	..	..	(1) 15+2.25*	100+2.0*
Orissa ..	(1) 6+2.25*	25+2.0*	..	..	(1) 15+2.25*	100+2.0*
Bengal ..	(1) 6+2.25*	25+2.0*	(3) 45+6.75*	225+6.0*	(1) 15+2.25*	100+2.0*
Bihar ..	..	..	..	..	..	..
United Provinces ..	(1) 6+2.25*	25+2.0*	..	..	(2) 30+4.50*	200+4.0*
Punjab ..	(1) 6+2.25*	25+2.0*	..	..	(1) 15+2.25*	100+2.0*
Sind ..	..	..	..	..	..	..
Bolshi ..	..	..	..	..	..	..
(7)	42+15.75*	175+14.0*	(3) 45+6.75*	225+6.0*	(9) 135+20.25*	900+18.0*

Expenditure.	
Recurring. (Rs., in lakhs)	Non-recurring. (Rs., in lakhs)
(7) 42+15.75	175+14.0
(3) 45+6.75	225+6.0
(9) 135+20.25	900+18.0
222+42.75	1300+38.00
264.75	1338.00

**Totals—**

Improvement	..
Conversion	..
Creation	..
Total (in lakhs)	..

\* Recurring and non-recurring expenditure in connection with a Department of Preventive & Social Medicine.

# SCHOLARSHIPS.

Years.	No. of admissions.	50 per cent. of this number.	Duration of scholarship in the two periods.		Amount payable @ Rs. 1,000 per year to each student.	
			1st five years.	2nd five years.	1st five years.	2nd five years.
1st year	2040	1020	..	..	Rs. 40,80,000	Rs. 10,20,000
2nd year	2040	1020	..	1 year	..	..
3rd year	3120	1560	4 years	2 years	46,80,000	31,20,000
4th year	3120	1560	3 years	3 years	31,20,000	46,80,000
5th year	3120	1560	2 years	4 years	15,60,000	62,40,000
6th year	4200	2100	1 year	..	..	..
7th year	4560	2280	..	5 years	1,34,40,000	1,05,00,000
8th year	4920	2460	..	4 years	..	91,20,000
9th year	5180	2580	..	3 years	..	73,80,000
10th year	5160	2580	..	2 years	..	51,60,000
			..	1 year	..	25,80,000
						4,98,00,000
	37,440					

## PERSONAL EDUCATION.

*Health Assistants.**1st five years.—*

Stipend at the rate of Rs. 20 per month per student for 60 students (2 classes in a year)—	Rs.	
$6 \times 60 \times 20$	=	7,200
For two courses ..	=	14,400
Miscellaneous expenses in connection with the field training including travelling expenses Rs. 1,000 per month	=	12,000
<b>Total</b>	=	<b>28,400</b>
For 24 centres $24 \times 28,400$	=	6,36,600
For five years $5 \times 6,36,600$	.. ..	<u><b>31,68,000</b></u>

*2nd five years—*

31,68,000 1st five years.  
31,68,000 2nd five years.

63,36,000 Total ten years.

## HOSPITAL SOCIAL WORKERS.

*1st five years.—**Recurring :*

- (1) Three trained workers from abroad, one for each centre, will mean  
Rs.  $3 \times 52,100 =$  Rs. 1,56,300
- (2) Associated staff—  
Basing on the figure in respect of 300 beds (in Peiping).  
One year = Rs. 37,020 for one year.  
For three years, we need only double this amount which will be  
Rs. 74,040.  
Three centres  $3 \times 74,040 =$  Rs. 2,22,120
- (3) Expenditure on the training of students abroad = Rs. 2,00,000  
**TOTAL = Rs. 5,78,420**



## MEDICAL RESEARCH.

(Provinces).

*Non-recurring Expenditure—*

1st five years	..	..	..	..	Rs.	20,00,000
2nd five years	..	..	..	..	..	20,00,000
1st ten years	..	..	..	..	..	40,00,000

Maintenance charges at 3 p. c. per year on the above expenditure—

$10 \times 20,00,000 \times 3$			
1st five years	$\frac{5 \times 100}{100}$	=	1,20,000
$20,00,000 \times 3 \times 5$			
2nd five years	$\frac{100}{100} + \frac{20,00,000 \times 3 \times 10}{5 \times 100}$		
		=	3,00,000 + 1,20,000
		=	4,20,000
1st ten years .. .. .	.. .. .	=	4,20,000 + 1,20,000 = 5,40,000

## RECURRING EXPENDITURE ON MEDICAL RESEARCH.

(General Provision).

1st five years at Rs. 10 lakhs per year	=	50,00,000
2nd five years	=	50,00,000
1st ten years	=	1,00,00,000

## Health education at Rs. 3 lakhs per year—

Five years	..	..	..	..	Rs. 15 lakhs.
Ten years	..	..	..	..	Rs. 30 lakhs.

## Special provision for industrial health services—

Five years	..	..	..	..	Rs. 75 lakhs.
Ten years	..	..	..	..	Rs. 175 lakhs.

*Maintenance charges on capital works in connection with certain services at 3 p. c. per annum.*

					1st five years. Rs.	1st ten years. Rs.
3 million unit	..	..	..	..	7,03,64,070	23,62,74,432
Malaria	..	..	..	..	8,808	38,028
					46,200	2,21,100
School health	..	..	..	..	7,920	27,720
Tuberculosis	..	..	..	..	14,54,100	63,75,450
Mental diseases	..	..	..	..	10,02,000	38,37,000
Leprosy	..	..	..	..	30,000	1,05,000
					8,40,000	37,80,000
Nutrition	..	..	..	..	38,300	1,27,050
Total	..				7, 37,89,398	25,07,85,780

## APPENDIX 56.

*Press Communiqué, dated the 18th October 1943, announcing the appointment of the Health Survey and Development Committee.*

In connection with post-war reconstruction plans the Government of India have appointed a committee, to be known as the Health Survey and Development Committee, to make a broad survey of the present position in regard to health conditions and health organisation in British India and to make recommendations for future development.

A drive to improve health conditions must necessarily be in the forefront of any programme directed towards improving the standard of living in the post-war period. If dissipation of financial resources and administrative effort is to be avoided, plans for the improvement of health organisation must be based on a comprehensive review of the health problem as a whole which will take account of, and place in their proper perspective, all the various factors affecting the health of the community with which health administration is concerned. The Government of India believe that a broad survey of the whole health field by a central committee will be of considerable assistance to Governments in preparing their post-war programmes and that the time has come when, in spite of the difficulties arising from war conditions, such a review must be undertaken.

The Committee appointed includes persons with practical experience of preventive public health work, medical relief, medical and public health education, industrial health conditions and other aspects of the health problem. The Committee will have power to appoint sub-committees to make preliminary inquiries into particular aspects of the problem. The procedure of the Committee will necessarily have to be adapted to war conditions and it will not be possible for the Committee as a whole to make tours of inquiry but it will be open to the Committee to have local inquiries made by small groups or sub-committees when such inquiries are essential for the adequate discharge of their task.

The composition of the Committee will be as follows :—

*Chairman*—Sir Joseph Bhore, K. C. S. I., K. C. I. E., C. B. E.

*Members*—

1. Rai Bahadur Dr. A. C. Banerjee, C. I. E., M.B. B.S. (All.), D.P.H. Director of Public Health, U.P.
2. K. B. Dr. Abdul Hamid Butt, M.B. B.S. (Pb.) D.P.H. (London), D.T.M. & H. (Eng.), Director of Public Health, Punjab.
3. Dr. R. B. Chandrachud, M.B. B.S., F.R.C.S., Chief Medical Officer, Baroda State.
4. Lt.-Col. E. Cotter, C.I.E., M.B., Ch. B., D.P.H., I.M.S., Public Health Commissioner with the Government of India.
5. Dr. D. J. R. Dadabhoy, M.D., M.R.C.P. (Lond.), ex-President of the All-India Association of Medical Women, Bombay.
6. Dr. J. B. Grant, B.A., M.D., M.P.H., International Health Division of the Rockefeller Foundation, Director, All-India Institute of Hygiene and Public Health, Calcutta.

7. Dr. Mohammad Abdul Hameed, M. D., M.R.C.P., Member of the Medical Council of India, Professor of Pathology, Lucknow University.
  8. Col. J. B. Hance, C.I.E., O.B.E., M.D., B. Ch. (Cam.), M.R.C.S., F.R.C.S.(Edin.), Director General, India Medical Service.
  9. Sir Henry Holland, C.I.E., M.B., Ch. B., F.R.C.S. (E.), C.M.S. Hospital, Quetta.
  10. Sir Frederick James, O.B.E., M.L.A., Member, Central Advisory Board of Health.
  11. N. M. Joshi, Esq., M.L.A.
  12. Dr. H. M. Lazarus, F.R.C.S. (Edin.), C.M.O., Women's Medical Service.
  13. Pandit L. K. Maitra, M.L.A., Member, Central Advisory Board of Health.
  14. Diwan Bahadur Dr. A. Lakshmanaswami Mudaliar, B.A., M.D. F.C.O.G., Vice-Chancellor, University of Madras, Member of the Medical Council of India.
  15. Dr. U. B. Narayanrao, L.C.P.S. (Bomb.), Medical Practitioner, Bombay, President, All-India Medical Licentiates Association.
  16. Dr. Vishwa Nath, M.A., M.D., D.P.H., D.T.M. & H., F.R.C.P., Member of the Medical Council of India, Medical Practitioner, Lahore.
  17. Maj.-Gen. W. C. Paton, M.C., M.A., M.B., Ch. B. (Edin.), F.R.C.S. (Edin.), Surgeon General, Bengal.
  18. B. Shiva Rao, Esq.
  19. Dr. B. C. Roy, M.R.C.P., F.R.C.S., President of the Medical Council of India.
  20. The Hon'ble Pandit P.N. Saprū, Member, Council of State, Member, Central Advisory Board of Health.
  21. Lt.-Col. B. Z. Shah, M.R.C.S., L.R.C.P., I.M.S. (Retd.), Superintendent, Mental Hospital, Poona, formerly Director of Medical Services, Sind.
  22. Mrs. Shuffi Tyabji, J.P., K.I.H., Bombay.
  23. Dr. Hemandas R. Wadhwani, M. B. B.S. K.I.H., J.P., Minister, Sind.
- Secretary*—Rao Bahadur Dr. K.C.K.E. Raja, L.M. & S. (Mad.), L.R.C. P. & S., L.R.F.P.S. (Edin. and Glas.), D.P.H., (Camb.), and D.T.M. & H. (Camb.).

## APPENDIX 56.

*Composition of Advisory Committees of the Health Survey and Development Committee.*

## (1) INDUSTRIAL HEALTH ADVISORY COMMITTEE.

The Hon'ble Mr. P. N. Saprú. (*Chairman*).

Mr. N. M. Joshi. (*Vice-Chairman*).

Lt.-General J. B. Hance.

Col. E. Cotter.

Sir Frederick James.

Dr. B. C. Roy.

Mr. B. Shiva Rao.

Dr. R. A. Amesur.

Dr. M. Ahmad. (*Member-Secretary*).

## (2) MEDICAL RELIEF ADVISORY COMMITTEE.

Dr. B. C. Roy. (*Chairman*).

Sir Henry Holland (*Vice-Chairman*).

Lt.-General J. B. Hance.

Major-General W. C. Paton.

Lt.-Col. B. Z. Shah.

Dr. R. B. Chandrachud.

Dr. D. J. R. Dadabhoy.

Pandit L. K. Maitra.

Captian A. Banerji. (*Secretary*).

## (3) MEDICAL RESEARCH ADVISORY COMMITTEE.

Lt.-General J. B. Hance. (*Chairman*).

Col. E. Cotter.

Dr. W. R. Aykroyd.

Pandit L. K. Maitra.

Bt.-Col. Sir Ram Nath Chopra.

Dr. Vishwa Nath.

Dr. C. G. Pandit.

Dr. V. N. Patwardhan.

Lt.-Col. H. W. Mulligan. (*Member Secretary*).

## (4) PROFESSIONAL EDUCATION ADVISORY COMMITTEE.

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Lt.-Col. H. M. Lazarus. (*Vice-Chairman*).

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Dr. J. B. Grant.

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 Dr. B. C. Roy.  
 Dr. M. A. Hameed.  
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 Dr. S. Ramakrishna (*Secretary*).

(5) PUBLIC HEALTH ADVISORY COMMITTEE.

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 Dr. J. B. Grant. (*Vice-Chairman*).  
 Lt.-Col. C. A. Bozman.  
 Sir Frederick James.  
 The Hon'ble Mr. P. N. Saprú.  
 Rai Bahadur Dr. A. C. Banerjea.  
 Khan Bahadur Dr. A. H. Butt.  
 Dr. Hemandas R. Wadhwani.  
 Mrs. K. Shuffi Tyabji.  
 Dr. B. C. Das Gupta.  
 Mr. B. Shiva Rao.  
 Dr. K.T. Jungalwalla (*Secretary*).



सत्यमेव जयते

## APPENDIX 57.

*List of written memoranda and reports considered by the Health Survey and Development Committee.*

## INDUSTRIAL HEALTH ADVISORY COMMITTEE.

1. Replies to the Industrial Health questionnaire by Dr. Donald Stewart, one of the leading Industrial Medical Officers in England.
2. Replies to the Industrial Health questionnaire by Dr. J. J. Heagerty, Director of Public Health Services, Canada.

*Sickness Insurance.*

3. A health service and sickness pay scheme for industrial workers in India by Dr. K. C. K. E. Raja and Dr. M. Ahmed.
4. A note on Prof. Adarkar's Sickness Insurance Scheme by Dr. M. Ahmed.
5. A note on the Administrative Machinery of the Industrial Health Insurance Scheme by Professor B. P. Adarkar.
6. Report on health insurance for Industrial Workers by Professor B. P. Adarkar, M. A., (Cantab.) Officer on Special duty, Labour Department, Government of India.

*Miscellaneous.*

7. Extract from a letter from Dr. E. R. A. Merewether, M.D., M.R.C.P., F.R.S.E., Barrister-at-Law, H. M. Senior Medical Inspector of Factories, to Sir Weldon Darlymple Champneys, Bt., D.M., F.R.C.P., Ministry of Health, Whitehall, London.
8. Scope and nature of welfare work relating to health in industry in India with special reference to Central Government undertakings by Mr. R. S. Nimbkar, Labour Welfare Adviser, Government of India.
9. Note on Industrial Health by Sir Frederick James (Points taken from the Report of the first British Industrial Health Conference, 1943).
10. Inspection note of the factories in Bengal by Sir Frederick James, O.B.E., M.L.A.
11. Copy of D. O. letter No. F. 1 (a)/9/44, dated the 4th January, 1944, from Mr. P. P. Pillai, International Labour Officer, Indian Branch, New Delhi, to Rao Bahadur Dr. K. C. K. E. Raja, Secretary, Health Survey & Development Committee, regarding ratification of international conventions concluded under the auspices of the League.

## MEDICAL RELIEF ADVISORY COMMITTEE.

*Drug Addiction.*

12. Memorandum on drug addiction by Dr. B. Mukerjee, Director, Biochemical Standardization Laboratory, Calcutta.

*Feldshers Training.*

13. A note on "Short" and "Long term" proposals for medical relief with special reference to the Russian and Chinese systems by Lt.-General J. B. Hance, C.I.E., O.B.E., K.H.S., I.M.S., and Lt.-Col. D. P. McDonald, I.M.S.

*Medical Relief in Rural Areas.*

14. A note on long-term and short-term programme of a 3-million unit by Dr. B. C. Roy and Dr. J. B. Grant.

15. American College of Surgeons, Manual of Hospital Standardization History, Development and Progress of Hospital Standardization.

*Mental Hygiene.*

16. Memorandum on " Mental Hygiene " by Dr. K. R. Masani.

17. Memorandum on " Prevention of Mental Diseases " by Dr. K. R. Masani, Director and Psychiatrist, Indian Institute of Psychiatry and Mental Hygiene, Bombay.

18. Summary of Short-term recommendations made in the memorandum on mental hygiene and the prevention of mental diseases by Dr. K. R. Masani, Director and Psychiatrist, Indian Institute of Psychiatry and Mental Hygiene, Bombay.

19. Memorandum submitted to the Health Survey and Development Committee on " Provision for patients suffering from Mental diseases " by Dr. K. R. Masani, Director and Psychiatrist, Indian Institute of Psychiatry and Mental Hygiene, Bombay.

20. Memorandum on ' Provision for Mentally Defective (Mentally Deficiency) Patients , by Dr. K. R. Masani, Director and Psychiatrist, Indian Institute of Psychiatry and Mental Hygiene, Bombay. .

21. Memorandum on the problems of Prevention and Treatment of Mental Disorders by Dr. G. Bose.

22. A brief outline of a scheme of Mental Hygiene Organisation by Lieut.-Colonel B. Z. Shah, I.M.S. (Retd.).

23. Memorandum on mental hygiene, prevention of mental diseases and provision for mental patients and mental defectives in India by Lieut.-Colonel M. Taylor, O.B.E., M.D., D.P.H., I.M.S., Medical Superintendent, European Mental Hospital, Ranchi.

24. Memorandum on the measures necessary for the prevention and treatment of mental disorders in India by Dr. M. V. Govindaswamy, M.A., B.Sc., M.B.B.S., D.P.M., Superintendent, Mysore Government Mental Hospital, Bangalore.

25. Report by Lt.-Col. M. Taylor, O.B.E., M.D., D.P.H., I.M.S., on the tour of mental hospitals in India.

*Miscellaneous.*

26. Note on the Post-war health policy and on the reconstruction of health services in India by Major-General J. B. Hance, I.M.S., Director General, Indian Medical Service.

27. A Health Service for India—The First Stage by Lieut.-Col. C. A. Bozman, I.M.S., Additional Public Health Commissioner with the Government of India.

28. Memorandum by the Countess of Dufferin's Fund Association regarding the part to be played by the Women's Medical Service in their post-war plans.

29. Letter from Dr. (Miss) Edith Brown, Principal, Women's Christian Medical College, Ludhiana, mentioning the conditions under which women should be asked to work in the villages.

30. Trends—Medical Relief.

31. A National Medical Service (received from the All-India Institute of Hygiene and Public Health, Calcutta).

32. A National Health Service—The White Paper proposals in brief.

#### MEDICAL RESEARCH ADVISORY COMMITTEE.

33. A note on Medical Research in India by Lieut.-Colonel S. S. Sokhey, I.M.S.

34. The future of Medical Research in India by Dr. V. N. Patwardhan.

35. Three notes on Medical Research by Major-General Sir John Taylor, C.I.E., D.S.O., I.M.S.,

36. Memorandum on Medical Research in India by Bt.-Colonel Sir Ram Nath Chopra, C.I.E., I.M.S. (Retd.).

37. Memorandum on Medical Research in India by Dr. B. M. Das Gupta.

38. Memorandum on Medical Research in India by Dr. V. R. Khanolkar.

39. A note on Medical Research in India by Dr. C. G. Pandit.

40. Note on Medical Research in India by Dr. G. Sankaran.

41. All-India Policy and Initial Steps for Medical Research in relation to industry by Dr. J. B. Grant.

42. Notes of discussion by General Hance and Dr. C. G. Pandit with Dean C. J. Mackenzie, President, National Research Council, Canada.

#### ORGANISATION SUB-COMMITTEE.

43. Suggestions for the formation of Ministries of Health at the Centre and in the Provinces by Drs. K. C. K. E. Raja and John B. Grant.

44. A note on (1) methods of improving local health administration and (2) the functions of the proposed district health organisation by Dr. K. C. K. E. Raja.

45. Action taken in the province of Madras to control local bodies in order to increase the efficiency of their administration in general and with special reference to their health functions by Dr. K. C. K. E. Raja.

46. A note detailing certain proposals under consideration by the Sind Government improving the health administration of local bodies by Dr. H. R. Wadhwani.

47. A note on the distribution of health functions between Departments of the Government of India (from the Department of Education, Health and Lands of the Government of India).



## PROFESSIONAL EDUCATION ADVISORY COMMITTEE.

*Basic Doctor.*

48. A memorandum on the training of Basic Doctor in India by Dr. Vishwa Nath.

49. Some suggestions regarding the " Basic curriculum for the Basic Doctor " of the future by Major General J. B. Hance, C.I.E., O.B.E., V.H.S., I.M.S.

50. Note on Dr. Vishwa Nath's memorandum by Prof. M. A. Siddiqui, Medical College, Lahore.

51. Note on " Basic medical qualification " by Dr. B. B. Yodh.

52. Memorandum on the training of " Basic Doctor " and some problems pertaining to medical education by Dr. A. L. Mudaliar.

53. Note on the teaching of physics in a medical college by G. Sankaran.

54. A further note on medical education in India by Lieut.-Col. M. McRobert, I.M.S.

55. Note on the compression of the course in medical education by Capt. M. G. Kini.

56. A scheme for medical education proposed by Dr. V. R. Khanolkar, etc.

57. A note embodying the recommendations of the sub-committee dealing with the curriculum for the training of the basic doctor on undergraduate teaching in preventive medicine and public health by Dr. J. B. Grant and Dr. K. C. K. E. Raja.

58. " Children's diseases " syllabus of studying by Dr. G. Coelho, M.R.C.P., Physician, B. J. Hospital for Children, Bombay.

59. The position of Physiology in the basic medical curriculum by Lt.-Col. S. L. Bhatia, I.M.S.

60. Note on the syllabus for training in ear, nose and throat by Dr. C. A. Amesur, M.S. (Lond.), D.L.O. (Eng.), Bombay.

61. Summarized note on an adequate minimum of instruction in Psychiatry in the undergraduate medical curriculum submitted by Dr. K. R. Masani.

62. Suggested syllabus for medical education by the members of the curriculum committee from Bombay.

*Dental Education.*

63. Memorandum on Dental Education and provision of Dental Services in India, submitted by the Dental Sub-committee consisting of Dr. C. D. Marshall Day, Dr. R. Ahmad and Dr. V. M. Desai.

64. Supplementary memorandum submitted by the Sub-committee on Dental Education consisting of Dr. C. D. Marshall Day and Dr. V. M. Desai.

65. Note on Dental Hygienists by Dr. R. Ahmad, Principal, The Calcutta Dental College and Hospital, Calcutta.

66. Memorandum on Dental Education and Progress in India by Dr. R. Ahmad, Principal, The Calcutta Dental College and Hospital, Calcutta.

67. Memorandum on the development of Dental Education in India by Dr. V. M. Desai, D.D.S., F.I.C.D., Dean, the Nair Hospital Dental College, Bombay.

68. Memorandum regarding the urgent need for the extension and improvement of dental education in India and the provision of adequate facilities for dental service by Dr. C. D. Marshall Day, Ph.D., D.M.D., M.S., B.D.S., F.I.C.D., Dean of the Faculty of Dentistry, Punjab University, Lahore.

*Medium of Instruction.*

69. Medium of instructions in medical schools and colleges in India by Dr. M. Abdul Hamid.

70. A note on the medium of instruction in medical schools and colleges by the Principal, Osmania College, Hyderabad.

*Nursing.*

71. Proceedings of a conference of representatives of nursing profession in India held in New Delhi on 28th, 29th February and 1st March, 1944.

72. A note on the position of nursing conditions in India by Miss E.E. Hutchings, Miss A. Wilkinson and Miss M. Craig.

73. A note by the Sub-committee consisting of Miss E. E. Hutchings, Miss A. Wilkinson and Miss M. Craig on the cost of implementing certain recommendations made in their note on the position of nursing conditions in India.

74. A note on the training of midwives at the Government Hospital for women and children, Madras, by Lieut.-Colonel H. M. Lazarus.

75. Suggested syllabus for a course in institutional and domiciliary midwifery for those students who are not taking the full general nursing course of three years by Miss Hutchings, Miss Wilkinson and Miss M. Craig.

76. Notes by Miss Hutchings, Miss Craig and Miss Wilkinson on the proposed budget for the first year of the short-term programme and for the long-term programme.

*Pathology.*

77. Note on the facilities available in India for the training of Pathologists by Dr. V. R. Khanolkar.

*Pharmacy.*

78. Memorandum on " Pharmaceutical Education " by Dr. B. Mukerji, M.D., D.Sc., F.N.I., F.A.Ph.S., Offg. Director, Biochemical Standardization Laboratory, Calcutta.

79. Memorandum on the training needed for the profession of pharmacy in India by J. C. David, M.B., Ph.D.

80. Pharmacy Training in India by Dr. Khem Singh Greval.

81. Letter dated 30th December, 1943, from Prof. N. K. Basu, Department of Pharmacy, Benares Hindu University, Benares.

82. Suggested syllabus for the degree course in Pharmacy (B. Pharm.) by Dr. B. Mukerji.

83. Suggested syllabus for the diploma course in Pharmacy by Dr. B. Mukerji.

84. Proposed composition of the Central Pharmaceutical Council (on the lines of the Indian Medical Council) by Dr. B. Mukerji.

85. Joint Memorandum on Pharmaceutical Education submitted by Dr. B. Mukerji, M. D., D.Sc., F.N. I., Director, Bio-chemical Standardization Laboratory, Calcutta.

*Post-graduate Training.*

86. A note on Post-Graduate Medical Education by Dr. A. L. Mudaliar, M.D., F.R.C.O.G., F.A.A.C.S.

87. Graduate and Post-graduate Medical Education.

*Registration.*

88. Note by Dewan Bahadur Dr. A. L. Mudaliar regarding medical registration on an All-India basis.

*Hospital Social Workers.*

89. Training of hospital social workers (Almoners).

90. Training of hospital social workers and demonstration in a Bombay Hospital by Dr. J. M. Kumarappa.

91. Note on Hospital Social Workers by Dr. J. B. Grant, C.B.E., Director, All-India Institute of Hygiene and Public Health, Calcutta.

92. A note on adequate training for medical social work by Dr. K. R. Masani, Director, Child Guidance Clinic of the Sir D. J. Tata Graduate School of Social Work, Bombay.

*Teaching in Pediatrics.*

93. A note on Undergraduate teaching in Pediatrics by Dr. J. M. Orkney, W.M.S., Professor of Maternity and Child Welfare, All-India Institute of Hygiene and Public Health, Calcutta.

94. A note on Post-graduate teaching in pediatrics by Dr. J. M. Orkney, W.M.S., Professor of Maternity & Child Welfare, All-India Institute of Hygiene and Public Health, Calcutta.

*Technicians.*

95. Proposals for the future training of the Laboratory Assistants and Radiographers by Dr. Mohd. Abdul Hameed, M.D., M.R.C.P. (Lond.), Professor of Pathology, King George's Medical College, Lucknow.

96. A further note on the training of laboratory technicians by Dr. M.A., Hameed, M.D., M.R.C.P. (Lond.), Professor of Pathology, King George's Medical College, Lucknow.

97. Training of Medical Technologists (received from the All-India Institute of Hygiene and Public Health, Calcutta).

98. Trends—Ancillary Medical Personnel.

*Training of Internees.*

99. The minimum conditions to be fulfilled by a hospital approved for training internees by Dr. V. R. Khanolkar, Tata Memorial Hospital, Bombay.

*Miscellaneous.*

100. Trends—Medical Education.

101. Administrative organisation of university medical education in India.

102. Report of the Syndicate Committee (Bombay) consisting of Sir Jamshed N. Duggan, Lt.-Col., A. S. Erulkar, etc., on medical education and revision of medical curriculum.

103. Standard Equipment for Medical Colleges.

104. A note on the Indigenous Systems of medicine and Homeopathy by Dr. K. C. K. E. Raja. -

105. Indigenous Medicine—Japan and China by Dr. John B. Grant, M.D., C.B.E.

106. A note indicating the numbers of medical men required to be trained and the cost of training in a thirty-year programme for providing one physician to 1,500 of the population in India.

#### PUBLIC HEALTH ADVISORY COMMITTEE.

##### *Drainage and Refuse Disposal.*

107. Memorandum on Drainage and Refuse Disposal by Dr. Gilbert J. Fowler.

108. Memorandum on drainage and sullage or sewage disposal by Mr. D. A. Howell, O.B.E., M. Inst. C.E.M.I. Mech. E., Superintending Engineer, Public Health Circle, Lahore.

109. A note on the existing legal provisions relating to drainage conservancy and refuse disposal by Dr. K. C. K. E. Raja.

##### *Food Adulteration.*

110. Note on the United States Federal Food, Drug and Cosmetic Act and the Federal Trade Commission Act, 1938.

111. A comparison of the main provisions of the food adulteration Acts in British India, the U.S.A. and England.

##### *Health Education.*

112. A note on Health Education and Publicity by Rai Bahadur Dr. Harnath Singh, Assistant Director of Public Health, Punjab.

##### *Housing & Town Planning.*

113. Memorandum on 'Town Planning' by U. Aylmer Coates, B. Arch., F.R.I.B.A., M.T.P.I., Provincial Town Planner to Government of Punjab.

114. Memorandum on town planning and housing by O.R. Koenigsberger, Dr. Engr., Government Architect and Secretary, Mysore Town Planning Committee.

115. Memorandum on town and country planning presented to the Health Survey & Development Committee appointed by the Government of India by Mr. B. R. Kagal.

116. A note on housing for the working classes in England by Dr. K. C. K. E. Raja.

117. National Planning for Town and Country in Great Britain (Summary of Uthwatt and Scott Committee's Report, with remarks by Mr. K. Subrahmanyam).

118. Report on town and village planning in India by Mr. B. R. Kagal.

*Leprosy.*

119. Leprosy Problem in Sind by Dr. H. R. Wadhwani.
120. A note on the repatriation of leprosy patients by Lt.-Col. E. Cotter, I.M.S., Public Health Commissioner with the Government of India.

*Malaria.*

121. Note on the investigation and control of malaria in India by Brigadier G. Covell, I.M.S., Director, Malaria Institute of India, Delhi.
122. Note on Malaria control in India by Brigadier G. Covell, I.M.S., Director, Malaria Institute of India, Delhi.
123. The Public Health Aspect of Malaria Control in India by Brigadier G. Covell, I.M.S., Director, Malaria Institute of India, Delhi.
124. Malaria in Sind by Dr. B. J. Ajwani.
125. Draft Malaria Control Act by Dr. A. C. Banerjea, Director of Public Health, U. P., Lucknow, and Dr. A. H. Butt, Director of Public Health, Punjab, Lahore.

*Maternity and Child Welfare.*

126. Maternity conditions in Sind by Dr. H. R. Wadhwani.
127. Maternal and Child Health Services by Dr. J. M. Orkney, Director, Maternity and Child Welfare Bureau, Indian Red Cross Society, New Delhi.
128. A scheme for an efficient maternity and child welfare organisation for a rural centre with a population of 50,000 by Dr. A. H. Butt with Dr. A. C. Banerjea's remarks on the scheme.
129. A scheme for an efficient maternity and child welfare organisation for an urban centre with a population of 50,000 by Dr. B. C. Das Gupta, Executive Health Officer, Bombay Municipality, Bombay.
130. Legal position of local authorities with respect to spending money on maternity and child welfare by Dr. K. T. Jungalwalla.
131. Memorandum on maternity and child welfare by Dorothy Satur, Lakshmi N. Menon, Gladys, Own John Baranbas and Zohra Illahibaksh, Members, Social Responsibility Committee, National Y. W. C. A., Lucknow.

*Nutrition.*

132. Note on Nutrition by Dr. W. R. Aykroyd.
133. Public Health and Nutrition by Dr. W. R. Aykroyd.
134. An outline of the problems of agriculture and nutrition in India—A note submitted by Sir Pheroze Kharegat and Dr. W. R. Aykroyd to the United Nations Conference on Food and Agriculture.
135. Report of the eleventh meeting of the Nutrition Advisory Committee of the Indian Research Fund Association held in New Delhi on the 27th and 28th March, 1944.

*Physical Education.*

136. Suggestions for the improvement of physical education in schools by J. Buchanan, Physical Director, Bengal.

137. Physical Education and Recreation for National Health by P. M. Joseph, Esq., Principal, Government Training Institute of Physical Education, Bombay.

138. A memorandum on physical education and national health by D. B. Kothiwala, Senior Assistant, Training Institute for Physical Education, Kandivili, Bombay.

139. Notes on the Y. M. C. A. College of Physical Education, Saidapet, Madras, by Dr. K. T. Jungalwalla.

140. Notes on the Government Training Institute for Physical Education, Kandivili, Bombay, by Dr. K. T. Jungalwalla.

*Plague.*

141. The present position of Plague in India by Lt.-Col. S. S. Sokhey, I. M. S.

142. A memorandum on the legislative aspects of enforcing rat proofing of grain stores by Dr. B. C. Das Gupta, Executive Health Officer, Bombay.

143. A note on the plague prevention measures in the Punjab by Lt.-Col. W. C. H. Forster, I.M.S.

*Public Health.*

144. A note on the state of the Public Health in British India by Dr. K. C. K. E. Raja.

*Public Health Engineering.*

145. Memorandum on the need for providing special facilities for training public health engineers in India as an essential part of the plans for post-war reconstruction, by Mr. K. Subrahmanyam, Professor of Sanitary Engineering, All-India Institute of Hygiene and Public Health, Calcutta.

146. Amplification of the memorandum on the training of Public Health Engineers by Prof. K. Subrahmanyam, Calcutta.

147. Memorandum on the immediate and future numerical requirements of public health engineers, by Prof. K. Subrahmanyam, All-India Institute of Hygiene & Public Health, Calcutta.

148. A note on the place of public health engineering in administration, both urban and rural, by Prof. K. Subrahmanyam, All-India Institute of Hygiene & Public Health, Calcutta.

149. Proposals for including an elementary course in public health for the degree courses in engineering and the diploma courses for engineering subordinates in engineering colleges.

150. A short course of training in public health engineering for engineering supervisors in small municipalities.

*Public Health Teaching.*

151. Undergraduate teaching in preventive medicine and public health by Dr. John B. Grant, M.D., Director, All-India Institute of Hygiene and Public Health, Calcutta.

152. A note on postgraduate teaching in public health by Dr. J. B. Grant.

*Quarantine.*

153. A note on Quarantine by Dr. K. C. K. E. Raja.

*Questionnaires—Replies to.*

154. Replies by Dr. J. W. Mountin, U. S. Public Health Service, to the questions on Public Health sent through General Hance.

155. Answers to the questionnaire on public health by Dr. Winslow, till lately Professor of Public Health, Yale University, U.S.A.

156. Replies to the questionnaire on public health by Dr. J. J. Heagerty, Director of Public Health Services, Canada.

157. Replies to the questionnaire on public health by Charles Seeley, of the Birmingham Regional Office of the Ministry of Health, England.

158. Replies to the questionnaire on public health by Dr. H. S. Raper, Dean of the Medical School, Manchester.

159. Answers to the questionnaire on public health by Dr. B. C. William, Public Health Department, Oxford.

160. Impressions of General Hance on his discussion with Dr. Thomas Parran, Surgeon General, United States Public Health Service.

161. Note by General Hance on a discussion with Drs. Phair, Mcghie and Gray of the Ontario Provincial Department of Health, Toronto.

162. Extract from the United States Public Health Service Act.

*Sanitary Inspectors*

163. Memorandum on the training of sanitary inspectors in India by Professor K. Subrahmanyam, Calcutta.

164. Facilities for the training of sanitary inspectors in the provinces and their scales of pay by Dr. K. C. K. E. Raja.

165. A note on the training of "Sanitary Inspectors" by K. C. K. E. Raja.

166. A memorandum on the state of public health in India and of the urgent need for the appointment of specialist sanitation engineers in the Government of India in the C. P. W. D., Provincial Public Works Department, Railways, Military Engineering Service and Municipalities and the Education and Training of Sanitation Engineer by Captain Mantle.

*School Health.*

167. School Health (received from the All-India Institute of Hygiene).

168. A note on the question of placing school medical service under the administrative control of the Ministry of Education, *verses* that of the Ministry of Health by Dr. B. C. Das Gupta.

*Smallpox.*

169. A note on smallpox by Dr. K. T. Jungalwalla.

170. A further note on smallpox and vaccination by Dr. K. T. Jungalwalla.

*Tuberculosis.*

171. Memorandum on Tuberculosis by Dr. P. V. Benjamin, Medical Superintendent, Union Mission Tuberculosis Sanatoria, Arogyavram, South India.

172. A note on Tuberculosis by Dr. A. C. Ukil.

*Venereal Diseases*

173. A note on venereal diseases by Dr. K.T. Jungalwalla.

174. A Comparative Study of Provincial and Indian State Acts Relating to Traffic in Women and Children issued by Association for Moral and Social Hygiene in India.

*Vital Statistics.*

175. A note on Indian Vital Statistics by Dr. K. C. K. E. Raja.

*Water Supply.*

176. Extracts from a memorandum on water supply by Mr. D. A. Howell, C.I.E., O.B.E., M.Inst., C.E. M.I. Mech. E.

177. Proposals for establishing Central and Provincial Water Boards for India by Mr. K. Subrahmanyam, Professor of Sanitary Engineering, All-India Institute of Hygiene and Public Health, Calcutta.

178. A further note on Provincial Water Boards by Prof. K. Subrahmanyam, All-India Institute of Hygiene and Public Health, Calcutta.

179. A note on the additional functions to be discharged by the proposed Central and Provincial Water Boards for promotion and control of drainage projects by Prof. K. Subrahmanyam, All-India Institute of Hygiene and Public Health, Calcutta.

180. Detailed note on the constitution and budget of a Central Water and Drainage Board by Prof. K. Subrahmanyam, etc.

181. Note on the establishment of Central and Provincial Water Boards by Mr. F. D. Tunncliffe, M.C., Assoc. M. Inst. C.E., Superintending Engineer, Public Health Engineering Department, Government of the United Provinces, Lucknow.

182. Note on the river Jumna, its pollution and the riparian rights of the inhabitants living on its banks by Mr. H. G. Trivedi, Superintending Engineer, Public Health Department, United Provinces, Lucknow.

183. Water Pollution Research by Dr. Gilbert J. Fowler, D.Sc., F. R., I.F.N.A.



*Miscellaneous.*

184. Trends—Public Health.

185. Extract from the P. E. P. report regarding 'Medical Research and Genetics and Public Health' supplied by Lt.-Col. D. P. McDonald, I.M.S.

186. A note on Karachi City by Mr. T. J. Bhojwani, M.A., J.P., Chief Officer, Karachi Municipal Corporation.

187. Public Health Work in the U.S.S.R. by Prof. B. V. Ognev.

188. Rational Public Health and Medical Expenditure. (Received from the All-India Institute of Hygiene & Public Health).

189. Post-war health planning for urban areas. (Reprinted from the journal of Indian Medical Association Vol. XII No. 12, September, 1943—Pp. 369—370 supplied by the Convener, Urban Medical and Public Health Sub-committee of the Bengal Branch of the Indian Medical Association.)

## GENERAL PAPERS.

*Population Problem.*

190. A note on population problem in India by Mr. M. W. M. Yeatts, C.I.E., I.C.S.

191. A summary of Mr. M. W. M. Yeatts's interview with the Health Survey and Development Committee on 8th April, 1944.

192. A note on population problem in India and elsewhere by Mr. J. P. Brander.

193. A note on birth control by Dr. K. C. K. E. Raja.

*Miscellaneous*

194. Note submitted by Dr. A. L. Mudaliar.

195. A memorandum by Sir Abdur Rahim.

196. Memorandum by Mr. T. Austin, Adviser to H. E. the Governor of Madras.

197. A note by I. H. Taunton, Esq., C.I.E., I.C.S., Adviser to H. E. the Governor of Bombay.

198. Report of Dr. Sir Mangaldas V. Mehta, Kt., Principal Medical Officer, Nowrosjee Wadia Maternity Hospital, Bombay.

199. Report of Dr. R. N. Cooper, Principal Medical Officer, B. J. W. Hospital.

200. A note by Mr. R. Manohar Lall, Y. M. C. A. Welfare Officer at Messrs Begg, Sutherland & Co., Ltd., at Cawnpore.

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*New Delhi, 18th December, 1945.*

HSB437510-17,000-4-2-48-GLPS



REPORT  
OF THE  
HEALTH SURVEY AND DEVELOPMENT.  
COMMITTEE



सत्यमेव जयते

Vol. IV

Summary

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## FOREWORD

In this foreword an attempt is made to present, in a nutshell, the main principles underlying the Committee's proposals for future health development in the country. These are:—

1. No individual should fail to secure adequate medical care because of inability to pay for it.

2. In view of the complexity of modern medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.

3. The health programme must, from the beginning, lay special emphasis on preventive work. The creation and maintenance of a healthy environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation, are essential. So long as environmental hygiene is neglected, so long as the faulty modes of life of the individual and of the community remain uncorrected, so long as these and other factors weakening man's power of resistance and increasing his susceptibility to disease are allowed to operate unchecked, so long will our towns and villages continue to be factories for the supply of cases to our hospitals and dispensaries.

4. The need is urgent for providing as much medical relief and preventive health care as possible to the vast rural population of the country. The debt which India owes to the tiller of the soil is immense and, although he pays the heaviest toll when famine and pestilence sweep through the land, the medical attention he receives is of the most meagre description. The time has therefore come to redress the neglect which has hitherto been the lot of the rural areas.

5. The health services should be placed as close to the people as possible in order to ensure the maximum benefit to the communities to be served. The unit of health administration should therefore be made as small as is compatible with practical considerations.

6. It is essential to secure the active co-operation of the people in the development of the health programme. The idea must be inculcated that, ultimately, the health of the individual is his own responsibility and, in attempting to do so, the most effective means would seem to be to stimulate his health consciousness by providing health education on the widest possible basis as well as opportunities for his active participation in the local health programme.

7. We consider it essential for the success of the scheme that its development should be entrusted to Ministers of Health who enjoy the confidence of the people and are able to secure their co-operation. Both in respect of legislation and of administration it is likely that some of the measures to be undertaken may offend existing social and religious practices, while others may involve control over the day to day life of the citizen. We therefore feel that it is only a Minister enjoying the confidence of the people who can carry such enactments through the legislature and ensure their practical application in the country.

In putting forward its proposals for a national health organisation, which incorporates these principles, the Committee has drawn up a long-term programme which, if implemented on the lines suggested,

## FOREWORD

should help to provide the people with a reasonably well developed service based on the newer and expanding conceptions of modern health practice. The attainment of this objective, which may take about 40 years, is to be achieved through successive stages of intensive effort directed towards the production of the necessary trained personnel and the creation and development of the organisations and institutions which will form essential parts of the community's health service. The Committee has attempted to outline, in some detail, the first and second five-yearly stages of such development and has also suggested certain objectives to be kept in view for the next five years, leaving subsequent developments to be shaped in the light of the circumstances existing at the time.

The doctor of the future should be a "social physician protecting the people and guiding them to a healthier and happier life". He should place prevention of disease in the forefront of his programme and should so combine remedial and preventive measures as to confer the maximum benefit on the community. The Committee's proposals for the training of the 'basic' doctor, the term applied to the medical graduate of the future, are designed to equip him for all such duties.

The active support of the people is sought to be secured through the establishment of Health Committees in every village and through the stimulation of local effort for the improvement of environmental sanitation, control of infectious diseases and other purposes. A wide programme of health education, covering all sections of the population, is also proposed for promoting the growth of such public support.



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सत्यमेव जयते

# REPORT OF THE HEALTH SURVEY AND DEVELOPMENT COMMITTEE

## VOLUME IV

### A SUMMARY OF THE REPORT

#### INTRODUCTION

1. Our survey of existing health conditions in India in volume I of the report extends to about 220 pages, while the recommendations for the creation of a better standard of national health through the development of an organised health service on modern lines are embodied in a second volume of over 500 pages. In these two volumes we have dealt, at some length, with India's health problems in order to present an adequate picture of the existing state of affairs and of the proposals for its improvement. In addition to such detailed consideration of matters relating to India's present and future health administration we feel that it may be of advantage to give, in a much smaller compass, the salient features of our report in the present volume. In this summary we have not strictly adhered to the chronological order of the chapters in the first two volumes of our report. It deals with different subjects such as personal health services, environmental hygiene, professional education, medical research and so on in separate sections and indicates briefly, in each section, the more important matters relating to the subject concerned in respect of both the existing conditions and of our proposals for their improvement.

#### THE STATE OF THE PUBLIC HEALTH IN BRITISH INDIA

2. In presenting a picture of health conditions in India we have confined ourselves to the period ending with 1941 in order to exclude the adverse effects of abnormal conditions arising out of the War, particularly after Japan's entry towards the end of that year. The present state of the public health in British India is low as is evidenced by the wide prevalence of disease and the consequent high rates of mortality in the community as a whole and, in particular, among such vulnerable groups as children and women in the reproductive age period. The death rate for the general population in British India was, in 1937, 22.4 per 1,000 inhabitants and for infants (children under one year of age) 162 per 1,000 live births. In 1941 the corresponding rates were 21.8 and 158 respectively. As a contrast the following figures for New Zealand and Australia are quoted:—

	<i>General death rate (1937)</i>	<i>Infantile mortality rate (1937)</i>
New Zealand . . . .	9.1	31
Australia . . . . .	3.4	28

## SUMMARY

The high rates of mortality in the community at all age periods are reflected in the very low expectation of life in India. We give below the expectations of life for new-born infants in New Zealand, Australia and British India.

	Expectation of life at birth	
	Males	Females
New Zealand . . . .	65.04	67.88 (1931)
Australia . . . . .	63.48	67.14 (1932-34)
British India . . . .	26.91	26.56 (1921-30)

New Zealand and Australia are two of the most healthy countries in the world and the figures quoted above give an indication of what has already been achieved in reducing mortality in the community and in prolonging the life of the individual in those countries. India has to go a long way before the health of the people is raised to the standards already reached by the other countries. In all countries in which health administration has made definite progress the expectation of life for females is higher than for males. India is an exception the reason being, as will be shown later, the high rate of mortality among women in this country due to causes associated with pregnancy and childbearing.

3. The rates of mortality among infants and children and among mothers are examined below in greater detail.

Deaths among infants and children under 10 years of age in British India and in England and Wales are shown below as percentages of the total deaths at all ages in the two countries.

*Deaths at specific age-periods shown as percentages of the total deaths at all ages*

	Under one year	1-5 years	5-10 years	Total under 10 years
British India (average for 1935-39).	24.3	18.7	5.5	48.5
England and Wales (1938) . .	6.8	2.1	1.1	10.0

In India, nearly half the total deaths are among children under 10 years of age and, of the mortality in this age group, one half takes place within the first year of life. The percentage for England and Wales in every age group is very much smaller.

### Maternal Mortality

4. About 200,000 women die every year in British India from causes associated with pregnancy and childbearing and, probably, about four millions suffer from varying degrees of disability and discomfort as a result of the same causes.

### The Incidence of Diseases

5. At least 100 million persons suffer from malaria every year, and the annual mortality for which the disease is responsible, either direct-

ly or indirectly, is about 2 millions. About 2.5 million active cases of tuberculosis exist in the country and 500,000 deaths take place each year from this cause alone. The common infectious diseases, namely, cholera, smallpox and plague, are also responsible for a large amount of morbidity and mortality, the extent of which varies from year to year. Among the different countries of the world for which statistics are available, India ranks high as one of the largest reservoirs of infection in respect of all the three. These and the other two are all preventible diseases and their incidence should have been brought under effective control long ago. In addition, endemic diseases such as leprosy, filariasis, guinea-worm and hook-worm diseases are responsible for a considerable amount of morbidity in the country, although their contribution to mortality is relatively small.

#### **Causes of the Low Level of Health in India.**

6. The maintenance of the public health requires the fulfilment of certain fundamental conditions, which include the provision of an environment conducive to healthful living, adequate nutrition, the availability of health protection to all members of the community, irrespective of their ability to pay for it, and the active co-operation of the people in the maintenance of their own health. The large amount of preventible suffering and mortality in the country is mainly the result of an inadequacy of provision in respect of these fundamental factors. Environmental sanitation is at a low level in most parts of the country, malnutrition and under-nutrition reduce the vitality and power of resistance of an appreciable section of the population and the existing health services are altogether inadequate to meet the needs of the people, while lack of general education and health education add materially to the difficulty of overcoming the indifference and apathy with which the people tolerate the insanitary conditions around them and the large amount of sickness that prevails.

7. Diet surveys carried out in different parts of the country have shown, in typical urban and rural groups, that the food consumed is insufficient to provide the necessary energy requirements in the case of some 80 per cent. of the families, that the diet is almost invariably ill-balanced and that there is, in terms of food factors, a deficiency of fats, vitamins and proteins of high biological value. The statistics for food production in India show a considerable margin of error, but such figures as are available suggest that, in regard to cereals which form the staple article of diet, the deficiency may be of the order of 22 per cent. of the country's requirements. For other articles such as vegetables, fruits, milk, meat, fish and eggs, the quantities now produced will have to be increased several times before adequate amounts will become available for the proper nutrition of the people.

8. While the extent of provision of hospitals and dispensaries in urban and rural areas varies considerably among the provinces, the rural population has everywhere been less adequately provided for than the urban. The inhabitants of the rural areas live more widely dispersed than those of the urban and the medical aid given by an institution becomes to that extent more restricted. In the United Provinces, for instance, one institution serves in the rural areas an average population of 105,626 distributed over an average number of 224 villages.

## SUMMARY

9. The quality of service rendered by these institutions leaves much to be desired. For instance, the average time given to a patient was noted, during our tours, to be 48 seconds in one dispensary and about a minute in another. The medical service given to the people under such conditions is bound to be of a perfunctory nature. The medical officers in charge of many dispensaries have, for long periods, been out of touch with modern medical practice without an opportunity to work in a well conducted hospital. Other defects include unsatisfactory conditions in regard to the design of, and accommodation in, institutions, considerable overcrowding in the wards and great insufficiency of the nursing staff.

10. The number of beds available in British India for the treatment of general and special diseases is about 78,000 or about 0.24 bed per thousand population, as against 7.14 in England and Wales and 10.48 in the United States.

### Inadequacy of Health Personnel

11. Some idea of the magnitude of the task to be accomplished in increasing, within the next 25 years, trained personnel of various type in order to provide a reasonably satisfactory health service to the people may be obtained from the following figures. We have given existing standards in the United Kingdom but have suggested for India lower ratios as the targets to be aimed at during the next quarter of a century. The reason is that the available numbers in the various categories of personnel are so small that even the attainment of the suggested ratios by 1971 will involve concerted, intensive and unremitting effort, on an unprecedented scale, by the authorities concerned.

Class of personnel	Number available now	Ratio of numbers in column 2 to the present population of British India (300 millions)	Existing ratio in the United Kingdom	Suggested ratio to be attained in 1971 in British India with an estimated population of 370 millions	Number required in 1971
1	2	3	4	5	6
Doctors	47,500	1 to 6,000	1 to 1,000	1 to 2,000	185,000
Nurses	7,000	1 to 43,000	1 to 300	1 to 300	740,000
Health Visitors	750	1 to 400,000	1 to 4,770*	1 to 5,000	74,000
Midwives	5,000	1 to 60,000	1 to 618†	1 per 100 births.	100,000
Qualified Pharmacists.	75	1 to 4,000,000	1 pharmacist to 3 doctors.	1 pharmacist to 3 doctors.	62,000
Qualified Dentists.	1,000	1 to 300,000	1 to 2,700	1 to 4,000	92,500

\*Based on 1935 figure.

†Based on 1948 figure.

## RECOMMENDATIONS

12. We have indicated above certain dark shadows in the health picture of the country. If it were possible to evaluate, with any degree of exactness, the loss India suffers annually through avoidable waste of human material and the lowering of human efficiency through malnutrition and preventible morbidity, the result would be so startling as to arouse the whole country and create and enlist an awakened public opinion in support of the war against disease. According to one authority the minimum estimate of the loss to India every year from malaria alone lies somewhere between 147 and 187 crores of rupees. A nation's health is perhaps the most potent single factor in determining the character and extent of its development and progress and any expenditure of money and effort on improving the national health is a gilt-edged investment yielding immediate and steady returns in increased productive capacity.

13. In drawing up a health plan certain primary conditions essential for healthful living must in the first place be ensured. Suitable housing, sanitary surroundings and a safe drinking-water supply are pre-requisites of a healthy life. The provision of adequate health protection to all covering both its curative and preventive aspects, irrespective of their ability to pay for it, the improvement of nutritional standards qualitatively and quantitatively, the elimination of unemployment, the provision of a living wage for all workers and improvement in agricultural and industrial production and in means of communication, particularly in the rural areas, are all facets of a single problem and call for urgent attention. Nor can man live by bread alone. A vigorous and healthy community life in its many aspects must be suitably catered for. Recreation, mental and physical, plays a large part in building up the conditions favourable to sound individual and community health and must receive serious consideration. Further, no lasting improvement of the public health can be achieved without arousing the living interest and enlisting the practical co-operation of the people themselves.

## MODERN TRENDS IN THE ORGANISATION OF A NATIONAL HEALTH SERVICE

14. A study of the tendencies apparent in some of the more progressive countries of the world in the development of organised health services for the community has been of great assistance to us. Broadly speaking, the modern trend is towards the provision by the State of as complete a health service as possible and the inclusion, within its scope, of the largest possible proportion of the community. The need for ensuring the distribution of medical benefits to all, irrespective of their ability to pay, has also been recognised. The general tendency appears to be towards basing the national health plan on a system of social insurance. Even in Soviet Russia, where medical care is free to all, the cost of the services is partly met from insurance funds, contributions towards these funds being made not by individual workers but by the factories and other institutions in which they work. We have come to the conclusion that, under the conditions existing in the country, medical service should be free to all without distinction and that the contribution from those who can afford to pay should be through the channel of general and local taxation. It will be for the Governments of the future to decide ultimately whether medical service should remain free to all classes

of the people or whether an insurance scheme would be more in accordance with the economic, social and political requirements of the country at the time.

15. Taking into consideration the need for ensuring adequate health service for the vast rural population of the country and the difficulty experienced in the past in attracting medical practitioners to the countryside, we have come to the conclusion that the most satisfactory method of meeting the situation would be to provide a whole-time salaried service, which would enable Governments to ensure that doctors are made available where their services are most needed. This conclusion is supported by the evidence of a number of representatives of medical associations, of private individuals and several medical administrators.

16. We have also come to the conclusion that the whole-time salaried doctors employed by the State should be prohibited private practice. In our scheme the same doctor will combine in himself, at the periphery, curative and preventive health functions and it seems almost certain that, without the prohibition of private practice, his preventive duties will not receive the attention they require. As regards medical relief, there was a general agreement among those whom we interviewed that prohibition of private practice was essential in order to ensure that the poor man in the rural areas received equal attention with his richer neighbour. We have therefore recommended the prohibition of private practice to the full-time salaried doctors employed by the State and have, at the same time, suggested scales of pay which, we believe, will provide reasonably adequate remuneration for the services they render.

17. The utilisation of the services of suitable medical men outside the health service on a part-time or even on an honorary basis will also be advantageous and even necessary, particularly in the earlier stages of our health programme. In the cities and some of the larger towns in the country, general practitioners with high qualifications and specialists are available for such employment.

### **The Health Programme**

18. We have drawn up our health plan in two parts, one a comprehensive programme for the somewhat distant future and the other a short-term scheme covering two five-year periods. We have taken the countryside as the focal point of our main recommendations, for the debt which India owes to the tiller of the soil is immense. When pestilence and famine sweep through the land, it is he who pays the heaviest toll and yet receives only the scantiest medical assistance. Further, nearly 90 per cent. of the people in India live in the rural areas and the basic problem before the country is the provision of adequate health protection to this preponderatingly large section of the community. We have therefore made the villager the chief beneficiary under our proposals.

19. We shall first refer briefly to our proposals under the long-term programme and then set out those which are recommended for each of the two five-year periods, which constitute the short-term programme. In doing so we shall take up first the district health organisation in respect of each programme. The machinery for the organisation and administration of the health services at

## **THE LONG-TERM PROGRAMME**

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the Centre and in the Provinces constitutes an integral part of both the long and short-term proposals and it will be described later.

### **THE LONG-TERM PROGRAMME**

20. The large variations that exist in the density of population in different parts of the country make it impossible to formulate a plan which can be applied without modification over all the provinces. The desirability of associating the activities of the proposed health organisation with those of other Departments of Government such as Agriculture, Education, Animal Husbandry and Co-operation has been recognised and it is therefore considered advantageous that, as far as possible, the administrative district should be chosen as the area for the development of the scheme. The populations of individual districts vary considerably from over five millions to a few hundreds of thousands or even less in some cases and therefore, in presenting the plan, an arbitrary figure of three millions for a district has been chosen. For the sake of convenience it will be referred to as the three million plan. In implementing the proposals the details that are given will have to be modified in the provinces so as to suit the size and population of their individual districts.

#### **The Three Million Plan**

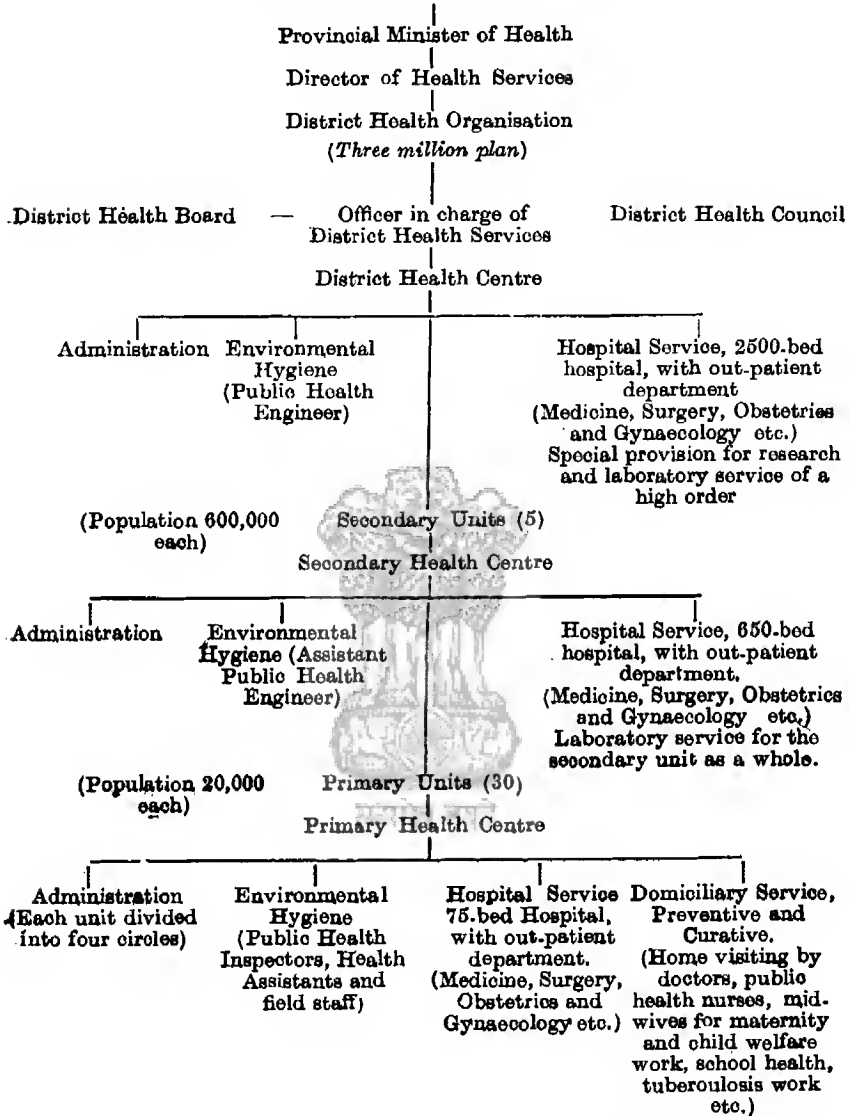
21. The district health organisation will have as its smallest unit of administration the primary unit, which will normally serve an area with a population of about 10,000 to 20,000. A number of such primary units (about 15 to 25) will together constitute a secondary unit and a varying number of the latter (about 8 to 5) will form the district health unit, the designation by which the district health organisation will be known. At each of the headquarters of the district, secondary and primary units will be established a Health Centre as a focal point from which the different types of health activity will radiate into the territory covered by each type of unit. The District Health Centre will possess general and special hospitals with a total bed strength of about 2,500 and all the consultant and laboratory services required for the diagnosis and treatment of disease on up-to-date lines. The administrative staff of the district health organisation will be located here and will exercise supervision over the district as a whole. Similarly, the Secondary Health Centre will be provided with hospital accommodation of about 650 beds and with equipment and other facilities on a generous scale, although not up to the standard of the District Health Centre. The administrative staff of the secondary unit will be attached to the Secondary Health Centre and will exercise supervision and control over the primary units included in it. The Primary Health Centre will have a 75-bed hospital and health administration over the area included in the primary unit will radiate from this Centre.



## SUMMARY

22. The district health organisation described above and its functions are shown below in diagrammatic form :—

### LONG-TERM PROGRAMME



The medical officers in charge of the Departments of Medicine, Surgery etc. in the hospital at the Secondary Health Centre will, in addition to their hospital duties, supervise work in their respective fields in the hospitals in the primary units and the corresponding staff in the hospital at the district headquarters will similarly supervise the work of the different departments in the secondary and primary health centre hospitals. Close and continuous guidance through advice and supervision, which should extend even to the remote villages, is fundamental to the success of the scheme and the administrative staff at the District and Secondary Health Centres will carry out this task in the different fields of health administration.

### **The Primary Unit**

23. Each primary unit will have six medical officers, six public health nurses and a 75-bed hospital with the requisite nursing staff, and all these should be utilised for organising a combined curative and preventive health service in the area. Over and above the hospital nursing staff there are provided six public health nurses, who should be qualified nurses with training in midwifery and, in addition, in rural health work in its preventive and remedial aspects. Of these, four may be put on to preventive work in the homes of the people. Each nurse so engaged should be able to deal with the health of school children, the welfare of mothers and children, tuberculosis work and other activities in the houses within her area of jurisdiction. The remaining two public health nurses and two medical officers will be available for organising and carrying out curative treatment in the homes of the people.

### **The Secondary Unit**

24. The staff employed in a secondary unit will be considerably larger than that of a primary unit. The Administrative Officer at the headquarters of the secondary unit will be responsible for the supervision and co-ordination of all curative and preventive health work in the whole area supervised by the secondary unit. There will be whole-time heads of the different departments of medicine, surgery, maternity, tuberculosis and pathology at the secondary unit hospital and they will perform the dual function of attending to the duties of their respective sections in the hospital and of inspecting periodically similar work carried on in the primary unit hospitals.

25. In addition to these, the secondary unit provides for two senior public health nurses and two senior sanitary inspectors who will be responsible for supervising the work of the corresponding officers in primary units. There is also an Assistant Public Health Engineer for supervising all activities in connection with environmental hygiene throughout the area controlled by the secondary unit.

### **The District Headquarters Organisation**

26. The provision for medical relief at the district headquarters is on a much larger scale than at a secondary unit. The number of beds in the hospital is 2,500 and the numbers of medical officers and other personnel employed are considerably greater than in a secondary unit. The provision of 2,500 beds need not necessarily be made in one large institution. These beds include provision for medical, surgical, obstetrical and gynaecological cases as well as for patients suffering from infectious diseases, mental diseases, tuberculosis and others. A number of institutions can be grouped together conveniently in the same area in order to provide the required facilities.

27. The secondary unit and district headquarters hospitals, with their better equipment and superior type of medical personnel, will be the institutions to which the more complicated cases admitted in the primary unit hospitals will be removed. The provision of ambulances and telephone connection between all the three types of hospitals are essential for ensuring that these institutions are utilised to the largest possible extent.

28. At all the three types of hospitals (primary unit, secondary unit and district headquarters hospitals) social workers are to be

## SUMMARY

employed. Their functions include, among other things, the visiting of the home of the patient in order to ascertain the causes underlying the disability for which he or she has sought the aid of the hospital and service as a connecting link between the hospital and the public in the treatment of the individual patient and the general health programme of the area concerned. Under our programme the treatment of disease has been approached not merely from the standpoint of affording the patient immediate relief but also from that of attempting to remove the causes which are responsible for his condition.

29. The health organisation briefly described above is expected to produce a reasonably satisfactory service for rural and urban communities alike. It is based mainly on a system of hospitals of varying size and of differing technical efficiency. These institutions will play the dual role of providing medical relief and of taking an active part in the preventive campaign. Work in connection with maternity and child welfare, tuberculosis, leprosy, etc., will be carried into the homes of the people from the hospitals, the outdoor organisations in respect of each of them being closely related to these institutions. The diagnostic facilities that the large hospitals will provide will also contribute their share to the preventive campaign. The social workers attached to these institutions will help to provide that preventive bias to the treatment of individual patients, in the absence of which the medical care bestowed on them may fail to produce lasting results.

30. By the time the long-term programme is completed the hospital accommodation available in the country will have risen from the present figure of about 0.24 bed per 1,000 of the population to 5.67 beds per 1,000. As regards health personnel, the numbers that will be required under certain categories and those now available are shown below:—

	Numbers required for the complete programme	Numbers now available
Doctors . . . . .	233,630	47,500
Nurses (including public health nurses) .	670,000	7,500 (including existing health visitors).
Midwives . . . . .	112,500	5,000
Pharmacists . . . . .	77,880	75

Is such a large increase in the numbers of the health personnel possible? An example of an unparalleled expansion of health personnel is furnished by Russia. In 1913 there were altogether 19,785 doctors in that country. By 1941 the number had risen to 141,600, an increase of seven times within a period of 28 years. In India the increase required under these proposals is only about five times the existing number of doctors, to be achieved in a longer period.

## THE SHORT-TERM PROGRAMME

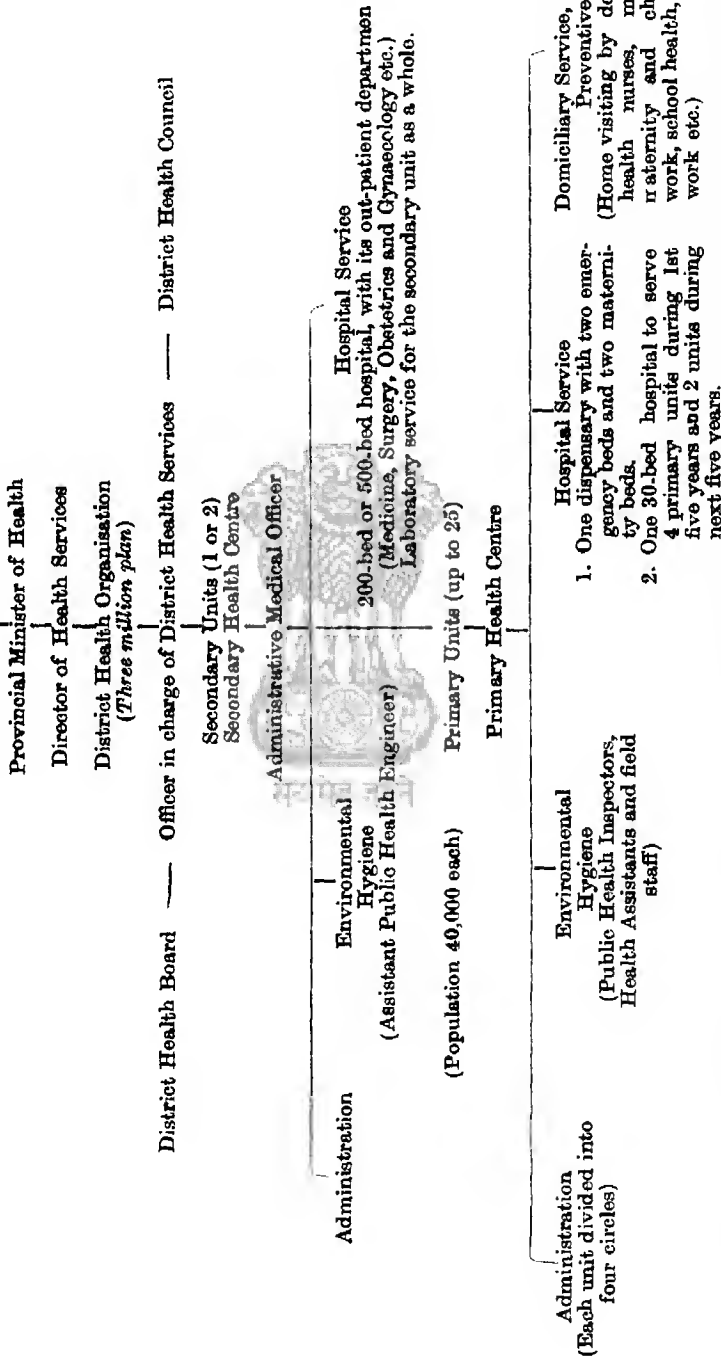
31. Our short-term proposals, which are intended to supplement and not supplant the existing health services, do no more than present a general picture for the guidance of the Provinces. They constitute, in our view, the irreducible minimum if tangible results are to be produced. The plan includes proposals for the establishment of personal and impersonal health services. Under the former head we propose a province-wide organisation for combined preventive and curative health work. This will provide, for each district, (1) a number of primary and secondary units, which are included in the district health unit and (2) special health services for mothers and children, school children and industrial workers as well as for dealing with the more important diseases prevalent in India, such as malaria, tuberculosis, venereal diseases, leprosy, mental diseases, and some others. The three important subjects of nutrition, physical education and health education have been dealt with in separate chapters in volume II of our report. Our recommendations regarding impersonal health services relate to town and village planning, housing, water supply, drainage and other matters regarding general sanitation. Specific proposals for the training of doctors, nurses and other categories of health personnel, for medical research and certain other important matters have also been made.

### **The Province-wide Health Organisation**

32. While the outlines of the general plan of the district health organisation will follow those indicated for the long-term programme the plan will be less elaborate. We suggest that, in view of the insufficiency of funds and of trained personnel, each primary unit should cover, during the first ten years, a population of 40,000, that the primary health centre should have a dispensary with two beds for maternity and two for emergency cases instead of a hospital and that the secondary health centre should start with a 200-bed hospital to be raised, by the tenth year, to 500 beds. We also suggest that the establishment of the district health centre may be postponed till after this period. The staffing and equipment of the health centres at the headquarters of the primary and secondary units will be on a reduced scale. In order to expand the existing meagre hospital facilities in rural areas we also suggest that a 30-bed hospital should be established, at the start to serve four primary units, and that, by the end of the first ten years, their number should be doubled so that one such hospital will serve two primary units.

33. The district health organisation suggested for the short-term programme and its functions are given below in diagrammatic form :—

### SHORT-TERM PROGRAMME



In the short-term programme the establishment of the organisation at the district headquarters is not contemplated. The administrative and supervisory functions exercised by the staff at the Secondary Health Centre will be on the lines indicated for the long-term programme.

34. The district health organisation should, from the start, be established in every district in a province. This organisation should begin with five primary units and one secondary unit and these should be gradually increased to 25 primary and two secondary units at the end of the first ten years. The following tabular statement indicates the expansion we suggest for the health organisation in a typical district:—

*Expansion of the scheme in a typical district*

	First year	Fifth year	Tenth year
Number of primary units .	5	10	25
Number of dispensaries .	5	10	25
Number of 30-bed hospitals .	1	2	13
Number of secondary units .	1	1	2
Number of 200-bed hospitals .	1	1	1
Number of 500-bed hospitals .	..	..	1

Starting with about a seventh of the average population of a district in British India the proposed health organisation will, it is expected, serve half the population of individual districts by the end of the first ten years.

### **The Primary Unit**

35. The primary health centre at the headquarters of the primary unit will be the focal point from which will radiate the various health activities contemplated in our programme. For each unit the staff required during the short-term programme will consist of 2 medical officers, 4 public health nurses for outdoor duty, 1 nurse attached to the dispensary, 4 midwives, 4 trained *dais* (as an *interim* measure till a sufficient number of midwives becomes available), 2 sanitary inspectors, 2 health assistants, 2 clerks, 1 mistry, 15 inferior servants and 1 pharmacist. This staff, with the exception of the public health nurses, midwives and trained *dais*, should be stationed at the headquarters of the primary unit, although their duties will extend over the whole area covered by the unit. The public health nurses, midwives and trained *dais* will be located at different places so as to make their services promptly available, wherever required.

36. We consider that the health programme in India should be developed on a foundation of preventive health work and proceed in the closest association with the administration of medical relief. A reduction in the demand for curative treatment can be secured only through successful preventive work. Both the doctors in the

primary unit should therefore perform curative and preventive health duties.

37. We have placed maternity and child welfare work in the forefront of our programme. Attention has already been drawn to the large number of preventible deaths, which occurs annually among children under 10 years of age and among women in the reproductive age period as the result of causes associated with pregnancy and childbearing. The supreme importance of dealing immediately with this section of the population is therefore obvious. Further, a progressive improvement of the public health depends largely on promoting the hygienic mode of life among the people by educating them towards this end. This education should be carried out intensely among women and children in order to produce lasting results. The woman doctor, the public health nurse and the midwife can carry the message of health to the homes of the people through their numerous contacts with women and children.

38. In the beginning the country will be faced with the necessity of providing, in many directions, services manned by imperfectly trained personnel with the ability to perform only limited functions. For instance, in order to promote school health work, selected school masters with limited training in the carrying out of certain duties will have to be utilised in the place of doctors and nurses until the latter become available in sufficient numbers. These teachers will work under the close supervision of the two doctors in charge of the primary unit in order to ensure that they carry out their duties satisfactorily.

39. No permanent improvement of the public health can be achieved unless the active participation of the people in the local health programme can be secured. We have therefore suggested the establishment, in each village, of a Health Committee consisting of five to seven individuals, depending on the size and population of the village. The members of the committee, who will of course be voluntary workers, can, after suitable training, help to promote specific lines of health activity. Their local knowledge and intimate contact with the people should enable the members of the committee to influence the former to accept and actively advance the health measures which are designed to promote the public welfare. The committee members should also be able to promote local effort, without payment, towards the carrying out of many measures which would otherwise prove prohibitive in cost. We consider that the development of local effort and the promotion of a spirit of self-help in the community are as important to the success of the health programme as the specific services which the health officials will be able to place at the disposal of the people.

### **The Secondary Unit**

40. From the very start, a secondary unit should be established in each district. The secondary health centre, which will be established at its headquarters, will help to provide a higher type of medical service than that available in primary units as well as supervision and guidance of the health activities in these units. When fully developed, a secondary unit may be expected to cover an area with an average population of about 800,000. In order to co-ordinate health administration with the activities of other departments of

Government, it will be of advantage if the area of a secondary unit can be made to correspond to that of a sub-division in the district.

### Hospital Provision

41. The anticipated numbers of new institutions in the 11 Governors' Provinces at the end of the first six years and of the first ten years respectively are shown below:—

	No. of dispensaries with four beds in each	No. of 30-bed hospitals	No. of 200-bed hospitals	No. of 500-bed hospitals
End of the first six years	2,293	639	216	<i>Nil</i>
End of the ten year period.	3,905	1,990	216	139

42. In addition there will be separate hospital provision for tuberculosis, mental diseases and leprosy. The existing number of hospital beds in British India is about 73,000 and, with the proposed new provision, the total accommodation expected at the end of the first five and first ten year periods will be as follows:—

At the end of the first five years—Approximately 183,000.

At the end of the first ten years—Approximately 353,000.

This programme of hospital expansion will raise the existing ratio of bed to population in the manner shown below:—

#### *Beds per 1,000 population*

At present	End of five-year programme	End of ten-year programme
0.24	0.55	1.03

As has already been pointed out, existing provision for hospital accommodation in England and Wales is 7.14 per 1,000 of the population and in the United States 10.48 per 1,000.

### Dental Service

43. It will not be possible to develop even the beginnings of a dental service during the first five years of the programme because of the total inadequacy of existing dental personnel. If our scheme of dental education should proceed satisfactorily it would be possible to organise dental service on a modest scale during the next five years. Our proposals include the establishment of dental sections in the 500 and 200 bed hospitals at the secondary health centres as well as the provision of travelling dental units for service in the rural areas. If the programme is completed on the lines envisaged by us there will be, at the end of the first ten years, 139 hospitals with 500-bed accommodation and 216 hospitals with 200 beds in each. The number of mobile dental units will be 710.



44. Reference should also be made to certain other matters which we consider to be of great importance from the point of view of ensuring the success of the health programme we have recommended. They are briefly dealt with below.

### **Housing Accommodation for the Health Staff**

We consider the provision of housing accommodation for the health staff essential in the interests of efficiency. Every health administrator is today faced with the problem of persuading doctors to settle in the villages. The absence in the rural areas of the amenities generally available in towns, including housing and water supply, is one of the factors retarding the flow of doctors from urban to rural areas. The same tendency is noticeable, though to a smaller extent, in respect of other types of health personnel. In the circumstances we consider the provision of housing is fundamental to the success of our scheme.

### **Co-operation of the Health Services with other Departments of Government**

The national programme of reconstruction should be developed on a broad front and, simultaneously with the inauguration of the health scheme, the reconstruction plans of other Departments of Government should be brought into operation in the same area.

### **Village Communications**

We must emphasise the vital importance of developing village communications in order to enable the health organisation to offer efficient service to the people. Without such development our whole plan for the rural areas may either be paralysed or lose the greater portion of its effectiveness. Further, the economic welfare of the village population largely depends on the development of rural communications and we stress the need for giving high priority to such development.

### **Ambulance**

The provision of ambulances for the transport of patients is an important factor in the improvement of the efficiency of the health services. For each 30-bed hospital two motor ambulances and one animal-drawn ambulance have been provided in our scheme.

### **Travelling Dispensaries**

In the sparsely populated parts of individual provinces it will be advantageous to provide travelling dispensaries to supplement the health services rendered by the primary health centres.

### **Utilisation of the Buildings, Equipment and Personnel made available from the Army after the War**

The needs of a modern Army have brought into existence a number of health services and the personnel, equipment and buildings connected with these can, in many cases, be utilised in the development of our health programme. Anti-malaria units, hygiene squads, hospitals constructed for war purposes, military camps, large airfields with such amenities as roads, water-supply and lighting,

motor vehicles of various types, should all be made available, on easy terms, for the purpose of developing the health programme.

### **Delhi Province as a Demonstration Area**

Some of us are of the opinion that Delhi Province is particularly suitable for being made a demonstration area by implementing here our proposals as well as those of other Committees which have put forward schemes for post-war reconstruction.

### **Objectives for the Third Five-year Term**

45. While the proposals outlined above relate to the first ten years of the health programme, certain broad suggestions are put forward as the objectives to be kept in view for the third five-year term.

(1) Hospital accommodation to be raised to 2 beds for every one thousand of the population.

At the end of the first ten years our scheme provides for one bed per 1,000 population.

(2) Expansion of the scheme so as to cover three-quarters of the population of individual districts, wherever possible.

(3) The creation of 12 new colleges in addition to the 43 to be established during the first 10 years.

(4) The establishment of a fourth set of 100 training centres for nurses.

(5) The training of 500 hospital social workers.\*

### **ORGANISATION AND ADMINISTRATION**

46. On the administrative side we propose :—

- (1) a Ministry of Health at the Centre;
- (2) Ministries of Health in the Provinces and
- (3) local area health administrations.

We consider it fundamental that the portfolio of health at the Centre and in the Provinces should be in charge of a separate Minister, so as to ensure his undivided attention being given to the development of the future health programme. The need for developing the health services in the closest possible co-operation of the people has

\* Drs. Vishwa Nath and Butt foresee that diarchical conflicts will arise out of the application of these proposals for medical relief in the districts. In their view the existing machinery of medical relief, however inadequate and unsatisfactory, is not ill-suited to furnish the foundations for evenly spread improvements. They advocate as even a distribution of facilities accruing from increased personnel, accommodation and equipment, as the requirements of special institutions, geography and density of population may permit. On the other hand the others consider that, if the suggestion of these two colleagues is accepted, the result may be a congeries of unplanned accretions to the existing organisations for medical relief and preventive health work and that one of the fundamental purposes underlying the health plan put forward in the report will not be fulfilled. The scheme is intended to promote, from the beginning, the development of remedial and preventive health work on a unified basis as well as to provide an integrated institutional and domiciliary service to the people. The existing curative and preventive health services are, on the other hand, functioning independently of each other with unsatisfactory results. In all progressive countries the requirements indicated above are considered as essential features of a modern health organisation. For these reasons the majority consider that the suggestion of Drs. Vishwa Nath and Butt would destroy the essential requirements of the Committee's plan.

already been stressed. Both in respect of legislation and of administration it is likely that some of the measures to be undertaken will offend existing social and religious practices. A Minister, who enjoys the confidence of the people and can secure their co-operation, can alone carry such enactments through the legislature and enforce their working in the country.

47. After giving careful consideration to the question of the existing distribution of health functions between the Centre and the Provinces and to the large measure of autonomy that the latter enjoy under the Government of India Act of 1935, we have come to the conclusion that certain principles should be taken into consideration in formulating plans for future development. These principles are:—

(a) That the wide measure of autonomy that has been granted to the Provinces should be respected to the utmost possible extent. Our proposals for the future will make for considerable changes in existing health administration and professional education and we therefore feel that, in carrying out these recommendations, the closest possible co-operation between the Centre and the Provinces will be essential. In order to minimise friction and to promote mutual consultation between the Centre and the Provinces in the formulation of health policy and its implementation, there should be established a Central Statutory Board of Health consisting of the Central and Provincial Ministers of Health. The Centre, with its larger resources in money and technical personnel, should help the Provinces with grants-in-aid for the development of their health programmes and with such technical assistance as may be required. One of the important functions of the Board will be that of making recommendations to the Central Government regarding the distribution of grants-in-aid.

In our view the co-operation that may be expected to develop, as the result of these proposals, between the Central and Provincial Ministers of Health on the one hand and between their administrative and technical staff on the other, should create a firmer foundation for the harmonious development of the health programme over the country as a whole than a reversal of the policy of decentralisation and a resumption of powers by the Centre to regulate and control development in the Provinces. We recognise that there will be certain exceptional circumstances in which the Central Government should have power to interfere in Provincial administration. It is, however, to be expected that the machinery for consultation and co-operation, which has been suggested above, should help to reduce these occasions to the minimum. We believe that a Centre acting with sympathy and imagination may well be able to hasten the pace of progress in the provinces by promoting a spirit of healthy competition among them in their task of providing progressively higher standards of health administration in their respective areas.

(b) The Ministry of Health, Central or Provincial, should be the ultimate authority responsible for all the health services operating within its jurisdiction and should have power to lay down and enforce minimum standards of health administration for those services which are within the immediate control of other departments (*e.g.*, railways, prisons, labour, etc.).

(c) There should be the closest possible co-operation between the Ministry of Health and other departments of Government in order to promote the pooling of all the available facilities, curative and preventive, in the interests of efficiency and of economy.

(d) The Ministries of Health, Central and Provincial, should have the advice and guidance of technical experts in the planning and maintenance of their health services. As has been pointed out in the White Paper recently issued by the Ministry of Health in England embodying proposals for a national health service, "the provision of a health service involves technical issues of the highest importance and in its administration, both centrally and locally, there is room for special devices to secure that the guidance of the expert is available and does not go unheeded." We recognise the need for such technical guidance and have therefore incorporated in our proposals a recommendation for the creation of standing councils of experts at the three levels of Central, Provincial and local area administrations. These councils will consist of representatives of the medical, dental, nursing and other professions.

### **Functions of the Central and Provincial Governments**

48. The main functions which we have recommended for the Central and Provincial Governments are broadly those for which they are responsible at present under the Government of India Act, 1935. In addition we have suggested that the Centre should take a definite lead in planning and promoting the development of health services, preventive and curative, in the country as a whole. Provincial activities in the field of health should be assisted and co-ordinated by the Centre through a system of grants-in-aid of approved schemes in the provinces and of technical assistance, where desired. Control of inter-provincial spread of communicable diseases, the sanitary control of inter-provincial traffic and the enforcement of standards regarding food and drugs in inter-provincial commerce should also be important functions of the Central Government.

In certain exceptional circumstances, the Centre should have power to take direct action in a province in the interests of the country as a whole. Such intervention should, as far as possible, be after consultation with the proposed Central Board of Health and, in cases requiring urgent action before such consultation could take place, the matter should be brought to the notice of the Board with the least possible delay.

49. We have recommended the establishment, in the provinces, of Provincial Health Boards and of Provincial Health Councils with composition and functions similar to those of the Central Board and Central Council.

### **Central and Provincial Health Services**

50. The principal technical adviser to the Minister of Health will be the Director General of Health Services at the Centre and the Director of Health Services in a Province, who will function in each case as the single administrative officer for the curative and preventive departments of health. These officers will be assisted by a suitable number of Deputy and Assistant Directors General or Directors as the case may be, who will be in charge of different functions.

### **Recruitment and Control of the Central and Provincial Health Services**

51. The following principles should, we recommend, guide the authorities concerned with the recruitment and control of the future Central and Provincial Health Services in India:—

(1) There should be separate and independent Central and Provincial health services appointed and controlled by the Central and Provincial Governments respectively, the venue of recruitment for

both being India. Recruitment to these services will be restricted to persons living in India except in the case of a small number of posts in connection with teaching and research institutions, for which it may be necessary to obtain suitable persons from outside the country. Such persons should be recruited from abroad on short-term contracts, every effort being made within the period of the contract to train a suitable Indian for the post.

(2) Appointments to posts in the teaching and research institutions should be made purely on merit. One-third of the general health service posts should also be filled on merit. In filling up the remaining posts consideration may be given to the need for communal representation, every community being given its share of the 66⅔ per cent in accordance with the proportions laid down by the Governments concerned. Of the candidates from individual communities the best available should be chosen. After admission into the health services promotion to higher posts should be regulated solely by merit.

(3) To secure opportunities for wider experience there should be exchanges of officers between the Centre and the Provinces to be arranged by mutual agreement.

(4) A proportion of the posts in the Provincial Cadres should have the same salary and status as in the Central service, so that the exchange suggested above may be facilitated.

(5) The Central and Provincial Services should be maintained as purely civil organisations.

(6) All members of these services should have opportunities of gaining experience of both urban and rural health work.

(7) There should be no reservation of posts under the Central or Provincial Governments for the civil branch of the Indian Medical Service.\*

### **Health Administration in Local Areas.**

52. We envisage a comprehensive health service, the success of which will mainly depend upon the fulfilment of the following conditions: (a) recruitment of the staff and the conditions of service should be on similar lines throughout the province so as to permit of the enforcement of fairly uniform standards of performance over the whole area and (b) there should be continuous and effective supervision by the higher technical staff over the work of the health personnel even in remote villages.

53. *District Health Board.*—These conditions can be fulfilled only by a health service maintained by a single authority and not through a number of separate services controlled by different local bodies. At the same time it is essential to associate the public with the formulation of health policy and with its implementation. We therefore recommend that, so far as health is concerned, in the place of the existing multiplicity of local health authorities with their separate staffs there should be a single health authority over the whole area operating through a unified executive staff. This authority may be designated the District Health Board and its jurisdiction will, in due course, extend over the district as a whole.

\* In the place of a Central Ministry of Health Drs. Vishwa Nath and Butt propose a Central Board of Health with a Technical Secretariat discharging specific functions. Their views on the recruitment of the health services are also different from those set forth above. Their views and our observations on them are given in paras. 27–31 of Chapter XVII of Volume II of the report.

54. We consider, however, that the deprivation of the health functions exercised by local bodies should be limited only to such as are in our opinion unlikely to be able to maintain the standard of service we have recommended. We therefore suggest that certain large municipalities such as Calcutta, Bombay, Madras and Karachi, which are governed by their own Acts, as well as other municipalities having a population of at least 200,000, which may be considered by the Provincial Government as being in a position to maintain an independent health service of the required technical efficiency, may be excluded from the jurisdiction of the District Health Board. All these large municipalities should develop and maintain health organisations on the lines suggested by us.

55. In the early stages of the programme only limited areas in each district will be brought within the operation of our scheme. In these areas there will be, as shown above, a unified health authority with a provincialised health service covering all categories of personnel. For the areas outside our scheme we recommend that, in order to secure an improvement of the health administration of existing local bodies, certain legal and administrative measures which have been taken in the province of Madras should be applied in other provinces also.

56. We have suggested that representation of the people on the Board should be partly secured by direct election by the people and partly by election, from their own ranks, by the local bodies in the areas covered by our scheme. We have also suggested, that, following the lines laid down in the Madras Public Health Act, 1939, every municipality included in the area under our scheme should be required statutorily to contribute to the District Health Board not less than 30 per cent. of its income from all sources other than Government grants and that every District Board or *panchayat* should similarly contribute not less than 12½ per cent. of its income from such sources. Obviously the actual amount of the contribution in each case will depend on the proportion of the population under the local body concerned, which is brought within our scheme. Such contributions and any grants sanctioned by the Provincial Government will constitute the funds to be administered by the Board.

57. While the Board will enjoy a large measure of autonomy in order to ensure that local opinion in the district is permitted to influence health policy, it is essential that the Provincial Minister of Health should have the power of ensuring compliance by the Board with the general policy laid down by him. We have also recommended that certain legal provisions that exist in the Province of Madras enabling the Chief Administrative Officer of the Public Health Department to recommend specific action by local health authorities in particular directions for the improvement of the public health and to enforce the carrying out of such recommendations, subject to the concurrence of the Provincial Government, should be made applicable to all the areas under our scheme.

#### **Recruitment and Control of the District Health Service**

58. After giving careful consideration to the question as to whether the recruitment and control of the district health service should rest with the Provincial Government or with the District Health Board concerned, we have come to the conclusion that the balance of advantage is heavily in favour of the provincialisation of this service.

In our view, such provincialisation should extend over all the posts in the district health organisation because; if a certain number of the more responsible posts are provincialised and the others are left under the Board, the resulting dual control must, we believe, lead to inefficient administration.

59. The district health organisation will be in charge of an officer to be designated the Officer in charge of the District Health Service. Under our proposals he will be a Provincial Officer whose services are lent to the Board. He should be responsible for carrying out the health policy laid down by the Board and we recommend that he should be its Secretary. This officer will be removed by the Provincial Government if a recommendation to that effect is passed by the Board by a two-thirds majority, taking into consideration its full strength.

#### **District Health Council**

60. We have already recommended the creation of a District Health Council consisting of representatives of different professions (e.g., those of doctors, dentists, pharmacists, nurses etc.) from the registered members of which the health service will be recruited. The functions of the Council will correspond to those of the Provincial and Central Health Councils. We recommend that the Officer in charge of the District Health Service should be the Chairman of this Council.\*

#### **Salaries.**

61. We have given considerable thought to the question of the scales of pay to be proposed for the health staff. Obviously the country cannot afford rates of remuneration which are out of all relation to its national income and are higher than those which economic conditions demand. Further, too generous a provision on salaries may well wreck or at least greatly handicap the implementation of any large scale health programme. The question of salaries, moreover, is not one which concerns medical and public health personnel alone. The necessity for establishing some measure of parity between the various Provinces in the matter of the salaries of their public health staff has been strongly impressed on us by a Provincial Minister of Public Health. Another important consideration, in determining the scales of pay, is that of the competitive attraction provided by non-State employers. In the circumstances we feel that the subject is of such complexity and importance as to require comprehensive examination at the hands of an *ad hoc* all-India Committee which should include medical men. The results of such examination will be of the utmost value to the Central and Provincial Governments. We have, therefore, recommended the establishment of such a Committee. For the purpose of estimating the cost of our proposals we have either adopted existing rates or assumed scales of pay which appear to us *prima facie* to be generally not unreasonable.

### **THE NUTRITION OF THE PEOPLE**

62. The national health campaign is concerned not only with the prevention of disease but also with the development of a healthy

\* Mr. P. N. Saprú holds views which are different from those of the other members regarding the constitutional aspects of certain of the proposals outlined above as well as the suggestion for a modification of the existing form of local health administration. His views are embodied in two minutes of dissent which are appended to Chapter XVII of Volume II of the report. Our reply to his remarks regarding local self-government will be found in paras. 58-61 of the same chapter

and vigorous population and improved nutrition plays a vital part in preventing sickness and in promoting positive health.

63. Under-nutrition and malnutrition exist widely in the country. According to the Director, Nutrition Research Laboratories, Coonoor, an insufficient and ill-balanced diet giving only about 1750 calories per day (as against the needed 2400 to 3000 calories) is typical of diets consumed by millions in India. Apart from inadequate nutrition being responsible for a lowering of the general standard of health of the individual, continued insufficiency of certain food factors in the diet will produce specific forms of disease. Such diseases are prevalent, to a varying extent, in different parts of the country. For instance, *beri beri* is not uncommon among adults and infants in the Northern Circars of the province of Madras, osteomalacia and rickets are prevalent in certain parts of Northern India, keratomalacia is a common cause of blindness in South India and goitre is not infrequent among the communities living in some parts of the Himalayan and sub-Himalayan regions.

64. The main defects of the average Indian diet are an insufficiency of proteins, mineral salts and vitamins. A general raising of dietary standards throughout the country is basically an economic problem, the solution of which depends on the scientific development of agriculture, animal husbandry and fisheries and the simultaneous development of industrial resources. We consider that food planning should have, as its ultimate objective, "the provision of an optimum diet for all, irrespective of income, and plans should be laid to reach the objective by forced marches, stage by stage, within a specified period of time."

65. As the average Indian diet is inadequate in respect of the quality and quantity of the protein consumed, one of the most urgent needs is the raising of protein consumption to the required level. Proteins of high biological value are of animal origin. A certain proportion of the protein consumed each day should be proteins of this type. We shall deal with three articles of food in this connection, namely, milk, fish and food yeast. Urea as a cattle feed deserves consideration in connection with increasing the availability of meat and its production will also be referred to briefly.

*Milk.*—The Director of Nutrition Research Laboratories, Coonoor, has suggested the inclusion of 8 ozs. of milk per day in the average Indian diet in order to improve its quality. Expectant and nursing mothers and children up to 14 years of age will need much more. We have suggested that, taking into consideration the existing demand for milk products, the target for realisation in the near future should be an increase in milk production to the extent of at least 110 per cent.

It has been brought to our notice that, very recently, the production of synthetic milk which, it has been claimed, has the same nutritive value as natural milk, has been developed on a laboratory scale in Great Britain. In view of the importance of the milk problem in India we desire to emphasise the need for immediate investigation into the claims put forward on behalf of synthetic milk and for promoting its production in India on a large scale, if these claims are justified.

*Fish.*—India's long coast-line, her numerous rivers, lakes and tanks afford great opportunities for developing the fish industry.



The total production of fish in India, both fresh water and marine is estimated at less than two crores of maunds per annum as against 9½ crores of maunds, the estimated requirement of Bengal alone where 90 per cent. of the people eat fish. These figures should help to give some idea of the extent to which the fish industry will have to be developed in India.

*Food yeast.*—Yeast is of value as a supplement to poor Indian diets because of its richness in proteins and vitamins of the 'B' group. Certain strains of yeast, which can be grown on molasses, produce palatable products of high nutritive value. We strongly recommend the immediate investigation of the possibility of producing food yeast on a large scale in India.

*Urea.*—It has been brought to our notice that, while the production of animal proteins, such as meat and milk, through a process of feeding natural foods to certain animals is a costly and uneconomical process, a simple chemical, urea, which can be produced in abundant quantities at a low cost, when fed to ruminants, is converted largely into proteins of the animal body. The production of urea may be linked with the process of manufacturing synthetic nitrogenous fertilisers and it is thus possible to promote the manufacture of both cattle food and plant food at the same time. We strongly urge that this suggestion should be carefully investigated without delay.

66. Our further suggestions for improving the nutrition of the people include the production, in India, of the different vitamins in sufficient quantities to meet the requirements of the country as well as the provision of facilities for the storage, transport and distribution of food, particularly of perishable articles such as milk, fish and fruit.

67. *Prevention of food adulteration.*—The subject of food adulteration was recently investigated in detail by a Committee of the Central Advisory Board of Health. We support all its recommendations and, in particular, desire to draw the attention of the Governments in the country to three of these, namely, the establishment, on a permanent basis, of a standing Central Committee for Food Standards, which we understand has now been created by the Government of India on a temporary basis, the formation of provincial cadres of public analysts and the establishment of food laboratories in association with central and regional bacteriological laboratories in the Provinces.

68. Lastly, in order to secure an improvement in the quality of the food made available to the public, we recommend that the principles of the Agricultural Produce Grading and Marking Act, which now applies only to agricultural products, should be made applicable to articles of food other than agricultural and that early action should be taken to give effect to this suggestion.

### HEALTH EDUCATION

69. According to modern conceptions, health education includes "not only instruction in purely health matters, but also those activities which are likely to influence favourably an individual's health knowledge, health attitude and health habits. Health education must promote health and health consciousness, and these are best achieved when health practices become part of an individual's daily life"

70. Health education is gradually taking its proper place in the life of the people in India, but progress has so far been slow. The teaching of hygiene is compulsory in all ordinary schools and it is also a subject of study in the curriculum of all normal schools and teachers' training institutions, but the standards of teaching vary from province to province. "The low standards of personal and environmental hygiene met with in many schools..... lead to the conclusion that something is wrong with the content of the syllabuses and the methods of teaching hygiene both in training institutions for teachers and in schools for children."

71. As regards the general population, health education is mainly carried out by the provincial public health departments. In most provinces a special health propaganda organisation exists in the office of the Director of Public Health. In certain provinces a good deal of hygiene publicity work is also being done in the rural areas by some other departments of Government. For instance in the Punjab, the Rural Reconstruction Department and the Co-operative Department have been actively co-operating in the health education of the people. In no province, however, has health education come up to the standard reached in the more advanced countries.

### **Our Recommendations**

72. We support the recommendation of the Central Advisory Boards of Health and of Education that the instruction of school children in hygiene should begin at the earliest possible stage. Such instruction in the early stages should be entirely practical and devoted to the formation of health habits and the promotion of personal hygiene. It is particularly important that the student should see, in actual operation, the sort of hygienic and sanitary arrangements he is taught and encouraged to demand for himself. School clubs, societies such as the Indian Red Cross Society and the St. John Ambulance Association and organisations like the Boy Scout, Girl Guide, Hindustan Scout and Bratachari movements can actively help in the development of the health education programme for school children.

### **Health Education of the General Population**

73. The main responsibility for assisting and guiding the health education of the general population should rest on the health departments of Governments and the establishment is recommended of properly constituted Health Publicity Bureaux as part of the Central and Provincial Health Departments. One of the functions of the Central Health Publicity Bureau should be participation in the active promotion of health education among all sections of the population and the giving of suitable advice and help to provincial health departments in organising health propaganda in their own territories. Another important duty of this Bureau should be the publication of an Indian Health Journal.

74. The organisation of health propaganda is a highly specialised task and it should therefore be entrusted to persons capable of producing results. The methods of propaganda which commercial organisations, such as the Indian Tea Association, have employed with great success should be studied and adopted, as far as practicable, in the development of the health education campaign.

75. The establishment of permanent health museums in the larger towns and cities is also recommended.

### PHYSICAL EDUCATION

76. Till the beginning of the twentieth century no one looked upon physical education as an integral and important part of general education. During the last 20 years revolutionary changes have taken place in all civilised countries in the concept and content of physical education and training.

77. Something has been done in India to give physical education and training their proper place in the educational structure, but a great deal remains to be accomplished. There is a great dearth of suitable teachers qualified to impart instruction in this important subject. We require many suitably equipped and staffed physical education schools and colleges in the country. At present there are only five physical education colleges in India. At a rough estimate the total number of physical training teachers trained at these institutions during the last 20 years, does not exceed 3,000—far too small a number for the needs of the country.

#### Our Proposals

78. (a) *The training of physical education instructors.*—For the proposed post-war schemes of education thousands of qualified physical training teachers will be required. We therefore recommend that there should be one or two physical training colleges in each province. Each institution should grant a recognised qualification. In addition, physical education should be made a compulsory subject in normal schools. A certain number of qualified physical training instructors should be sent abroad at State expense for higher training. On return they should be employed in responsible administrative and teaching posts, where their special training would be of value.

79. (b) *A physical training programme for the community.*—In the beginning it may be advantageous to develop a single organisation to serve the needs of school and college students as well as of the general public. The school master, because of his general education and of the influence he is able to exert on successive groups of pupils, is in a position to evoke a favourable response from the public in the matter of physical education and culture. He should therefore be utilised for developing a physical education programme for the adult population. It will be necessary to establish a suitable organisation in each province and this may, with advantage, be made part of the Provincial Education Department. It is essential that this organisation should establish close liaison with the Health Department.

The national physical education programme should include indigenous games, sports and folk dances. A blending of the old and the new in an attempt to evolve a sound scheme of physical culture is advisable. In this programme separate provision should be made for students, the male adult population and for girls and women.

### HEALTH SERVICES FOR MOTHERS AND CHILDREN

80. We have drawn attention to the high rates of morbidity and mortality prevailing among mothers and children in this country.

Measures directed towards a reduction of sickness and mortality among these sections of the community must have the highest priority in our programme of health development.

*The Primary Unit.*—The staff available for health service for mothers and children in a primary unit will consist of a woman doctor, four public health nurses, four midwives and four trained *dais*. The provision for institutional service will consist of a dispensary at the headquarters of the unit and a hospital of 30 beds serving four such units together. At the dispensary there will be provision for four beds, of which two will be for maternity cases. In the 30-bed hospital six beds will be set apart for maternity and gynaecological cases and there will be four cots for children.

81. At the headquarters of each primary unit and in the places in which 30-bed hospitals are located, the services of a medical officer will be available and there will also be provision for a small number of maternity beds. With these facilities it should be possible to organise a maternity and child welfare centre on a reasonably efficient basis. Its range of activity can be expanded as and when more trained personnel and funds become available and communications improve. The functions of the centre will include the following:—

(a) to get in touch with as many pregnant women in the area as possible and to persuade them to visit the clinic regularly, so that periodical examinations may be carried out and a record of their medical history kept;

(b) to provide for the skilled assistance of a midwife or trained *dai* at the time of delivery and for domiciliary visits by her for two weeks thereafter;

(c) to keep the mother and infant under observation, if possible, for a year;

(d) to teach mothercraft in all its branches and to inculcate sound hygienic habits in the mother and child;

(e) to keep children under observation, if possible, till five years of age;

(f) to organise periodical talks, by suitable persons, for husbands and fathers in order to secure their co-operation in the development of a healthy and happy home and

(g) to aim, in general, at becoming the focus of social activity in the area as far as mothers and children are concerned.

Whenever practicable, a playground for children of two to five years of age should be provided as close to the centre as possible, with toilet accommodation for mothers and children and with bathing facilities.

82. In the other three circles of each primary unit, to which we have already referred in describing the short-term health organisation, the resident staff will be only a public health nurse, a midwife and a trained *dai*. The woman medical officer of the unit should visit the headquarters of each of these units once a fortnight. The public health nurse should hold a weekly session while the woman medical officer should attend every alternate session. The same lines of activity should, as far as possible, be followed in the peripheral circle as those described for the maternity and child welfare centre at the headquarters of the primary unit.

83. *The Secondary Unit.*—The 200-bed hospital at the headquarters of the secondary unit should have about 50 beds reserved for maternity and gynaecological cases. In the second five-year period of the short-term programme the 200-bed hospitals constructed during the first five years will, it is hoped, be enlarged so as to provide 500 beds. In this case the provision for maternity and gynaecological cases should be raised to about 125 beds. The better facilities thus made available in these institutions will make a higher type of service possible, while the telephone and ambulance organization, which we have recommended, will help to extend these facilities to the more serious cases occurring in the primary units.

84. *The Provincial Headquarters.*—At the headquarters of each province there should be, on the establishment of the Director of Health Services, a competent woman doctor with wide experience in the organisation of health services for women and children.

### **Social and Economic Factors**

85. The two most important among these factors are inadequate nutrition, including malnutrition and under-nutrition, and the strain resulting from over-work in the home or outside.

*Nutrition.*—The pregnant woman, nursing mother and the growing child require a more generous and nourishing diet than the general population and the health services for these two sections of the population, howsoever elaborate and efficient, will fail to produce satisfactory results unless simultaneous measures are taken to improve their nutrition. An annual provision has been suggested in the budget of each primary unit in order to enable the woman medical officer to make suitable additions to the diet of pregnant women, nursing mothers and growing children.

*Overwork.*—The strain resulting from overwork affects a woman's health both during pregnancy and in the postnatal period. In the chapter relating to industrial health the grant of maternity benefits and compulsory abstention from work for a period of six weeks before and six weeks after confinement are recommended for all women employed in industry. We have suggested that these concessions should, in due course, extend to all women gainfully employed outside their homes.

### **Nurseries**

86. The provision of nurseries or *creches* to relieve the mother, especially the working woman, from her responsibility for the care of the child during her hours of work, has been a noticeable development in all highly industrialised countries. In this connection we wish to draw attention particularly to what has been accomplished in the Soviet Union for the development of nurseries as an integral part of the child welfare organisation (*vide* Appendix 13, Volume III). The nursery in Soviet Russia serves a three-fold purpose, *viz.*, that of relieving the mother, of caring for the child and of educating the mother and child. The aim is to make children healthy in body and mind, to draw out their innate faculties and to make them self-reliant.

### **Maternity Homes**

87. The establishment of private maternity homes, in response to the growing demand of the public for institutional facilities for

confinement, is a noticeable feature in some of the larger urban centres. The strictest possible control should be exercised by local health authorities over the establishment and maintenance of such institutions. The provincial Ministry of Health should prescribe suitable standards in respect of these homes and should see that they are enforced.

## HEALTH SERVICES FOR SCHOOL CHILDREN

88. In India, school health services are practically non-existent, and where they exist, they are in an undeveloped state.

### The Functions of a School Health Service

89. The duties to be performed by a school health service fall into two main groups: (i) health measures, preventive and curative, which include (a) the detection and treatment of defects, physical and mental and (b) the creation and maintenance of a hygienic environment in and around the school, and (ii) measures for promoting positive health. The last should include (a) improvement of the nutritional state of the child, (b) physical culture and (c) health education by formal instruction and the practice of the hygienic mode of life.

The duties enumerated in (i) above should be performed by the health organisation while those indicated in (ii) will devolve on the teacher. There should, however, be close co-operation between the health and education staffs.

### Some General Suggestions

90. (i) In each primary unit the male medical officer should normally be put in charge of the school health service.

(ii) To begin with, this health service should be restricted to primary school children, their number being limited to 1,000, which is as much as the medical officer can look after efficiently.

(iii) At least two teachers from each school should receive training in certain elementary health duties and should receive an additional remuneration for attending to such duties.

### Stages of Development

91. The proposed school health organisation should first be developed in an area close to the headquarters of a province, in association with the Department of Preventive Medicine in the medical college located there. The second stage would mark the extension of the school health programme to the districts in two steps, namely, to the headquarters of the secondary units and subsequently to the headquarters of individual primary units. Two more stages are envisaged, these being extensions of the scheme so as to include (1) the whole area of individual primary units and (2) the students of secondary and high schools and of colleges.

92. The school health work to be carried out in a primary unit should include all the main functions of a school health service to which we have already referred. We suggest that a school clinic should be established at the headquarters of each primary unit to perform duties in connection with the school health programme in the same manner in which the maternity and child welfare centre we have recommended is intended to help in the promotion of health

work among mothers and children. Besides providing treatment for minor ailments to the pupils in all the schools included in the scheme, the clinic should undertake certain specialised types of service such as dental care and the treatment of conditions relating to the eye, ear, nose and throat, which are relatively common among children. Such provision will be supplemented by a certain amount of routine treatment carried out in the school by the two specially trained teachers referred to above, under the guidance and supervision of the school medical officer. Follow-up work in the homes of the children by the public health nurse in order to discover and rectify, as far as possible, such defects in the home environment as are responsible for the illhealth of the pupil is also an important part of the preventive school health campaign.

93. We desire to see the school clinic developed into an organisation for bringing together the children, the parents and the teachers. For this purpose periodical meetings should be arranged at which interesting and educative programmes should be developed. Educational films can be shown, short talks on health matters arranged and people with special talent for music and other forms of entertainment, whether among the pupils, teachers or parents, encouraged to play their part towards making such gatherings a success. The atmosphere of goodwill that can thus be developed will be of advantage to all.

#### **Co-operation between the Health and Education Authorities**

94. *The District.*—If our suggestions for the future development of local self-governing institutions are carried out, there will be a District Health Board and a District Education Board functioning over practically the whole area of individual districts. In each district, a Joint Committee of the District Health and District Education Boards should be established and this body should be responsible for ensuring that the necessary co-operation between the health and education authorities is secured.

95. *Provincial headquarters.*—At the headquarters of the province there should be a Co-ordinating Committee with the Director of Public Instruction and the Director of Health Services as members. The managements of private schools and of approved associations of teachers and of parents should also be represented on this Committee, which will advise Government on all matters relating to school health administration, including the distribution of grants-in-aid.

#### **OCCUPATIONAL HEALTH INCLUDING INDUSTRIAL HEALTH**

96. The conditions affecting the health of the worker may, broadly speaking, be divided into two groups, namely, those which he shares with the other members of the general community among whom he lives and those which are associated with the occupation he pursues. In regard to the latter there may be special hazards to health arising out of particular occupations. The development of anthrax by those handling wool or skins and hides or poisoning by lead, chrome and other substances which are used in a variety of trades or manufacturing processes are examples of such special hazards. There are also other factors which have their influence on the health of the worker and these include the lighting, ventilation and general sanitation of

the workshop or factory, the dust and noise associated with the working environment and the provision that exists for rest pauses, meals and personal cleanliness. Over and above the general provision for health protection which the worker can share with the other members of the population, he has the right to claim that special measures should be taken to counteract the adverse effects of those factors which are associated with his occupation. The provision of such special health measures is the function of an industrial or occupational health service. To a greater or less extent, all those who are gainfully employed outside their own homes will require the services of the occupational health organisation. While recognising this as the ultimate objective we realise that, in the immediate future, Governments will have to concern themselves with measures mainly for industrial workers, including within that term those who are employed in factories, docks, mines, plantations, transport services and certain other occupations.

### **The Functions of an Industrial Health Service**

97. The functions of an industrial health service have been well described in the following words by the Social and Preventive Medicine Committee of the Royal College of Physicians, London, in their Second Interim Report which deals with industrial medicine:—

- (a) to promote the general health of the worker by providing a good working environment and fitting him to the latter;
- (b) to prevent occupational disease;
- (c) to assist in the prevention of injuries at work;
- (d) to organise a service for emergency treatment;
- (e) to help in restoring the injured and disabled to full working capacity;
- (f) to educate workers in the preservation of health and promotion of wellbeing and
- (g) to promote research and investigation.

These may be accepted as the objectives to be aimed at in organising an industrial health service in India.

98. The proposed industrial health service will not minister to the general medical needs of the workers. This function will have to be performed by the health service for the community as a whole. The industrial health organisation is intended to meet the needs of the worker in respect of that group of factors affecting his health which are associated with the occupation he pursues. The two services are complementary to each other and will together provide him with adequate medical care. The industrial health organisation should form an integral part of the Provincial Health Department and should be developed as such.

99. We understand that the creation of a Central Health Insurance Fund, which will be raised by contributions from Government, employers and workers and will be utilised for the benefit of the workers, is under contemplation. If the proposed Central Fund comes into existence, it should be possible, by grants from it to promote the development of an even higher level of general health service for industrial workers than that envisaged under our short-term scheme for the community. Further grants from this fund, if available, could be utilised for establishing an industrial health organisation on the lines indicated above.



100. While these proposals for an industrial health service will obviously take time to materialise, we have put forward certain recommendations for early consideration and appropriate action by Governments. These recommendations cover a wide field and it is only the more important ones among them that are referred to here. For more detailed information reference should be made to Chapter X of Volume II of our report.

### **Maternity Benefit**

101. The maximum period for maternity benefit for women workers under the different Provincial Acts is four weeks before and four weeks after childbirth. Under the International Labour Convention the period recommended is six weeks in both cases and we endorse this recommendation. During these periods a woman worker should be paid her full wages, because it is just at this time she requires nourishing food and special treatment.

### **Hours of Work**

102. From the health point of view, we recommend that the maximum hours of work should be reduced to 45 hours a week, i.e., 8 hours a day for five days and 5 hours for another day in the week and that the Factories and other Acts should be amended accordingly.

In the case of seasonal factories, which may be obliged to work under considerable pressure during only a part of the year, this maximum may be increased after taking into account such relevant factors as the extent of hazard to health which the occupation involves and the distance that the workers will have to walk back to their homes.

We recommend an interval for the mid-day meal of not less than one hour, exclusive of working hours.

The period during which a worker may be continuously on night duty should be limited by statute to a fortnight.

### **Housing**

103. In our opinion the housing of the industrial population is primarily the responsibility of the Governments concerned. The following minimum standards of housing are, we consider, required for the health of the industrial worker and his family.

- (i) For a single man: a room 10 ft. x 12 ft. x 10 ft. and a verandah 8 ft. x 8 ft. x 10 ft. For a group of such quarters there should be provided community kitchens, latrines and bathing places in accordance with the standards to be prescribed by the Provincial Government. Where common kitchens are not provided, provision should be made for *choolas* on the verandahs with suitable chimneys for the outlet of smoke. Where latrines and bathing places for common use are erected, they should be at a reasonable distance from the quarters and, if possible, connected by a covered way for protection during bad weather.
- (ii) For a family: for a married couple, two rooms 10 ft. x 12 ft. x 10 ft. with a verandah, kitchen, bath-room and latrine. For a family including grown up children the accommodation should be increased by at least one extra room of similar size.

(b) In regard to sanitary conveniences, we suggest that, as far as possible, septic tank and soil distribution systems should be introduced so that the handling of nightsoil may be avoided.

### **The Nutrition of the Workers**

104. Our recommendations for improving the nutrition of the workers include making it obligatory for industrial establishments employing a minimum number of workers to maintain canteens providing suitably balanced diets at reasonable cost, the encouragement of workers by employers to observe regular meal hours; the strengthening and stricter enforcement of the law relating to the sanitary control of the production, distribution and sale of food, including measures against adulteration, the active promotion of schemes designed to improve milk production and its supply as an article of food to workers and the establishment of nutrition sections in Provincial Health Departments, which should carry out nutritional surveys among industrial workers and assist in improving the nutrition of workers through educative work among employers and employees.

### **The Zoning and Location of Industry**

105. (a) Town and Rural Planning Acts should be passed by Provincial Legislatures setting up in each Province a separate Ministry for Housing and Town and Rural Planning with wide powers to deal with the housing of the industrial population and with the zoning and location of industry.

(b) Before the establishment of any new industry or factory is agreed to by the Provincial Government, the Minister should satisfy himself that, in the lay-out, adequate provision is made for the housing of workers, for their transport to and from the factory and for adequate environmental amenities.

(c) We wish strongly to reiterate the recommendation of the Royal Commission on Labour that Provincial Governments should take steps to prevent industries being established in places where there will not be sufficient room for adequate housing or other necessities such as water supply, electric power, etc. This should be the function of the Ministry of Housing and Town and Rural Planning if established, and, under the appropriate legislation, rules should be framed to regulate the growth of industries from this point of view.

(d) Where possible, having regard of course to the relevant economic factors, new industries should be dispersed in rural areas so that the local inhabitants may derive the fullest benefit from industries being brought within their immediate circle. The present system of establishing factories near or in big towns, where the workers are forced to live in crowded tenements and under artificial and insanitary conditions, is harmful alike to the town dwellers and the workers themselves. The health problem of workers in such industries would be greatly simplified if industrial establishments could be located in rural surroundings.

### **Employment of Children**

106. (a) The minimum age for employment in industrial establishments, docks, etc., should be raised to 15 and persons between 15 and 17 should be eligible for employment as adolescents on the certificate of the certifying surgeon.

(b) the minimum age for the employment of children on plantations and public works should be 13.

(c) In course of time when the compulsory school leaving age is raised and adequate educational facilities become available, the employment of children under 15 should be abolished for all types of industrial establishments and occupations.

## HEALTH SERVICES FOR THE MORE IMPORTANT DISEASES

107. We shall deal here with the specific measures necessary for controlling the prevalence of the following diseases.

1. Malaria.
2. Tuberculosis.
3. Smallpox.
4. Cholera.
5. Plague.
6. Leprosy.
7. Venereal diseases.
8. Hook-worm disease
9. Filariasis.
10. Guinea-worm disease
11. Cancer.
12. Mental diseases and mental deficiency.

### MALARIA

108. We have already pointed out that malaria is by far the most important disease in India from the point of view of morbidity and mortality and that the economic loss it entails is immense. A tragic feature of the situation is that much of the malaria in the country is man-made. In many cases roads, railways and irrigation projects have a sinister account to their credit, their embankments having caused conditions of water-logging favourable to the breeding of the malaria carrying types of mosquitoes. The failure of irrigation engineers to provide for adequate drainage when water is brought into previously dry areas has been another fruitful cause of the spread of the disease, recent examples being certain areas in Sind, the province of Madras and Mysore.

### Our Recommendations

109. *Antimalaria organisations in the Provinces and at the Centre.*—The Director, Malaria Institute of India, has pointed out that “an essential preliminary to the successful control of malaria in India is the formation of an adequately staffed *permanent* malaria organisation in each province, the activities of which should be linked up with those of the central organisation of the Government of India”. We fully endorse this view. Our recommendations, therefore, include the establishment of antimalaria organisations in the provinces as well as the strengthening of the staff of the Malaria Institute of India in order to enable it to fulfil its important tasks of advising provincial administrations in the development of antimalaria measures, of co-ordinating such work in the provinces and of training the higher types of malaria personnel for the country as a whole.

110. The general provincial plan we have recommended is the creation of an organisation at the headquarters of each province and

the establishment of a number of malaria control units, each under a medical officer specially trained in antimalaria work, for operating in the affected areas in different parts of the province. The most essential requirements are (a) the provision of trained staff in adequate numbers and (b) the supply of drugs, appliances and other equipment necessary for carrying out effectively the campaign against the disease. We deprecate the idea of spending large sums of money on the erection of elaborate buildings in the early stages of our programme.

### Drugs for Treatment

111. Quinine and mepacrine are the two drugs which are widely used for the treatment of malaria. There is already an indication that an even more effective synthetic product, paludrine, is likely to come into the field at an early date. We recommend that the following three general principles should guide the production of quinine and other antimalaria drugs:—

1. the prices at which antimalaria drugs are made available to the people should be sufficiently low to enable the poorest classes to obtain them in adequate amounts for the effective treatment of the disease.
2. these drugs, in whatever provinces they may be produced, should be made available, on an equitable basis and on reasonable terms, for the needs of all parts of the country and
3. no delay should be allowed to occur in developing their production.

We as a Committee would prefer to leave to the Governments in the country the responsibility for deciding whether private enterprise should or should not be associated with the production of quinine and other antimalaria drugs.\*

112. *Quinine and mepacrine.*—If the estimate of 100 million individuals suffering from malaria every year is reasonably correct, it seems safe to assume that at least 120 to 150 million cases of the disease will have to be treated annually. The Malaria Commission of the League of Nations has recommended 75 grains of quinine as the minimum quantity required for the treatment of a case. On these estimates of malaria incidence in India the amount of the drug necessary for the country as a whole will be in the neighbourhood of about 1·5 million pounds per year, if quinine is alone used for treatment. The average annual consumption of the drug in the pre-war period in India was 210,000 pounds and, of this amount, only about a third was produced in India. The quantity consumed every year in this country would provide adequate treatment for about 19·6 million patients. As the objective to be kept in view for the immediate future, we recommend that sufficient quinine and mepacrine should be provided to meet jointly the requirements of at least 50 million patients. As regards quinine our immediate objective should be the raising of its production to the pre-war level of consumption in India from indigenous bark alone. As regards mepacrine, provision should be made for its production in the country in sufficient amount to meet the requirements of 30 million patients.

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\* Sir Frederick James desires to see that private agencies are given the fullest opportunity to take part in quinine production with technical advice and a price guarantee provided by the State. His views are set out in a note which is appended to the section on malaria in volume II of our report.

**Anti-malarial Insecticides**

113. The cultivation of the pyrethrum plant has been successfully undertaken in various parts of India including Kashmir, the Punjab Hill States, the United Provinces, the Central Provinces, Madras and Orissa. It has been estimated that, in order to make the country self-sufficient, pyrethrum cultivation will have to be extended to about 120,000 acres so as to produce an annual output of about 15,000 short tons (2,000 lbs. for a ton) of pyrethrum flowers. In D. D. T. an even more powerful insecticide has come into use.

114. As an insecticide the relationship of D. D. T. to pyrethrum is somewhat similar to that of mepacrine to quinine in the treatment of malaria. There is the possibility in both cases of the synthetic substance replacing the use of the other. The cultivation of pyrethrum can, in this event, be replaced at short notice by other crops.

**TUBERCULOSIS**

115. Annually about 500,000 deaths take place from tuberculosis in India and about 2·5 million open cases of tuberculosis exist in the country. These patients are continually disseminating infection among those with whom they come in contact. There is reason to believe that the incidence of the disease is higher in urban and industrialised areas than in rural regions. Owing to the migration of the labour population between industrial and rural areas and the increased facilities for rail and road transport, the tendency has been for tuberculosis to spread to the country-side. Certain factors such as malnutrition and under-nutrition and insanitary and overcrowded housing conditions also contribute their share to the dissemination of infection.

116. An essential requirement for controlling the spread of tuberculosis is provision for the isolation and treatment of infective cases. As against an estimate of 2·5 million infective patients in the country the total number of beds available for isolation is in the neighbourhood of 6,000. The number of doctors with sufficient experience of tuberculosis work to qualify them for posts in tuberculosis institutions does not probably exceed 70 or 80, while those who have had a short course of four weeks in the subject may number about 250 or 300. Fully trained tuberculosis health visitors are, in all probability, only about 100.

117. This brief statement of the existing position should help to show the magnitude of the health problem which tuberculosis presents in this country and the total inadequacy of the existing facilities for dealing with it.

**Our Recommendations**

118. In order to provide a comprehensive and integrated service the tuberculosis organisation should include, (1) a domiciliary service, (2) clinics, (3) hospitals, (4) after-care colonies, (5) homes for the incurable and, in addition (6) certain ancillary services.

119. *A home isolation and treatment service.*—A scheme for organised home treatment has been working in Delhi during the past few years under the guidance of the New Delhi Tuberculosis Clinic maintained by the Tuberculosis Association of India. This scheme has attained only very limited success, the reasons being (1) certain difficulties arising out of the war, (2) the extremely unsatisfactory

housing of the poorer sections of the community and (3) the inadequacy of the funds made available for its working.

120. The question of housing seems to present the greatest difficulty, particularly in respect of tuberculosis patients of the poorer classes, who live in one-room tenements where isolation is impossible. We recommend that, as a part of the antituberculosis campaign, local authorities should construct and maintain a number of suitable dwellings into which the patient and members of his family can be removed. Patients among the poorer sections of the community will, on such removal, require to be provided with accommodation free of charge.

121. *The tuberculosis clinic.*—The clinic forms the centre from which curative and preventive work in tuberculosis will spread into the homes of the people. The treatment facilities it offers will help to cure a certain number of patients, while the more advanced cases will be sent for treatment in hospital. Those patients whose condition is too advanced for attendance at the clinic, will receive domiciliary treatment from the medical and nursing staff of the clinic. During visits to the home the patient will be advised, by the doctor and the nurse, to carry out effective isolation, contacts will be persuaded to attend the clinic for examination and early detection of the disease and steps will be taken to promote the welfare of patients and their families by establishing contact between them and voluntary organisations interested in welfare work.

122. *Tuberculosis hospitals.*—The provision of sufficient hospital accommodation to meet the requirements of the country is bound to take many years and therefore in the early stages, only such patients as are likely to benefit should be admitted to hospitals.

123. Our proposals for the development of hospitals and clinics during the short-term programme are given below:—

#### *Institutional service.*

The first five-year period :

- (1) the establishment of a 200-bed tuberculosis hospital for each unit of 10 million population;
- (2) The establishment of a large clinic (to be designated the "Main Clinic"), with facilities for the training of medical and non-medical tuberculosis personnel, at each of the places where the 200-bed hospital will be created and
- (3) The establishment of clinics of a smaller type at the headquarters of each district in British India. The total number required, after deducting the 33 main clinics, will be 183.

Second five-year period :

- (1) 33 more 200-bed hospitals;
- (2) 33 more main clinics at the same places where the new hospitals will be located and
- (3) 183 more district clinics.

The clinics and hospitals can serve only limited areas around the places where they are located. Even so, in these limited areas, a domiciliary tuberculosis service should be organised in association with

each clinic. A certain number of suitable cases will be sent by the clinic to the nearest tuberculosis hospital for more satisfactory treatment than can be provided locally.

124. *After-care of patients.*—In a considerable proportion of cases tuberculosis patients do not completely recover their previous health and, in order to prevent relapse, it is essential that less strenuous working conditions and a more hygienic home environment should be provided for them on their return from hospital. To meet these requirements after-care colonies should be established in close association with every tuberculosis hospital.

125. *Homes for incurables.*—The need here is for the provision of such care as will make the final phase of sickness reasonably comfortable for the patient. We recommend that, while Governments should undertake the building and equipment of such institutions, their maintenance can be suitably entrusted to philanthropic or religious organisations interested in social welfare, Governments undertaking to meet a substantial part of the expenditure through generous grants.

126. *Travelling tuberculosis units.*—One way of extending the activities of the tuberculosis organisation outlined above is by providing travelling tuberculosis clinics based on the district clinic and working as far into the rural areas as possible. These units will have motor vehicles so equipped with all the necessary drugs and appliances, including provision for x-ray examination of patients, as to enable them to carry diagnostic and treatment facilities of a reasonably high order to the areas served by them. These units should have a fixed itinerary and should make about 3-4 visits per month to each of the 30-bed hospitals and dispensaries at the headquarters of individual primary units in the areas under the scheme. Apart from the diagnostic and treatment facilities which these units can offer, they should also help the tuberculosis campaign by carrying out intensive education propaganda in those areas.

## SMALLPOX

127. Smallpox is one of the three major epidemic diseases of India, the other two being cholera and plague. During the period of 60 years, 1880-1940, the average annual rate of smallpox mortality per hundred thousand of the population has varied from 10 to 80. Even after making allowance for such variability, there is reason to believe that the total incidence of the disease has decreased in the country as a whole. For instance if the two ten-year periods, 1902-11 and 1932-41, are compared and due allowance is made for the increase in the population of the country, the rates of mortality from smallpox per 100,000 of the population are seen to be 40 and 25 respectively. Nevertheless, it is a matter for serious concern that the average number of deaths per year from smallpox for the period 1932-41 should have been as high as 70,000. The annual epidemiological reports which are published by the League of Nations show that the rate of incidence of smallpox in India is the highest among all the countries for which statistics are given.

128. Striking evidence of the fact that the vaccination campaign in the country has not so far been carried out effectively is that, of

the total number of smallpox deaths at all ages, high proportions occur among infants under one year of age and among children between 1 to 10 years. During the five-year period, 1937-41, deaths due to smallpox among infants under one year, when expressed as percentages of the total mortality from this cause at all ages, ranged from 12.1 to 19.7 and, during the same period, the corresponding percentages for children between one and ten years varied from 19.2 to 30.5. If effective primary vaccination is being enforced in the country, it is children under ten who should have the highest measure of protection.

129. One of the serious consequences of smallpox is that, not infrequently, those who recover from it lose their sight partially or wholly. Blindness is a very serious handicap in life to all persons and is particularly so in the case of children with the prospect of a much longer period of disability than for those who lose their sight at a more advanced age.

### **Our Recommendations**

130. *Primary vaccination and revaccination.*—Primary vaccination was compulsory in 1941 in only about 81 per cent of the towns and 62 per cent of the rural circles in British India. In the province of Bombay primary vaccination was compulsory only in 4.9 per cent of the rural circles while in the North-West Frontier Province, the United Provinces, Sind, Assam, Coorg and Ajmer-Merwara it was not enforceable even in a single rural circle. Revaccination has been made compulsory as a routine measure only in the province of Madras.

131. We consider it essential that primary vaccination should be made compulsory throughout the country without delay. We also recommend that other Provincial Governments should, as early as possible, follow the example of the Government of Madras in making revaccination compulsory.

132. *The training of vaccinators, their recruitment and conditions of service.*—There is considerable variation in the provinces as regards the training given to vaccinators, the methods of their recruitment and their conditions of service. The duration of the training varies from 8 to 10 months and the salary paid to them ranges from a minimum of Rs. 10/- per month in Bengal to a maximum of Rs. 50/- to a first class vaccinator in Madras. In the provinces of Bihar and Orissa the vaccinators employed in rural areas are given no salary at all, the fees they may realise from the people for vaccinations carried out in their homes being their sole remuneration. They are normally engaged for work only during the vaccination season, October to March. Such conditions of service cannot attract and keep the right type of worker.

133. The lowest figure for the average number of vaccinations performed in a year by a vaccinator was recorded in Bihar in 1939, namely 1,520, as against an average of 2,951 for British India as a whole and the highest figure of 7,587 for the Punjab.

134. In the areas under our scheme vaccination against smallpox should be one of the normal functions of the public health inspectors, public health nurses and midwives employed in each primary unit



and the employment of a special class of vaccinators is not necessary. Vaccination is only one of the many forms of specific protection against particular diseases which the health department should provide for the people, and the operation itself is so simple that there is no justification for the employment of a special staff for this purpose. During the first year of the working of the programme the total population of 40,000 in a primary unit should be vaccinated. For this individual members of the staff mentioned above will be required to devote only about 18 to 20 days of work.

135. In the areas outside our scheme it is equally essential that an intensive vaccination campaign against smallpox should be organised without delay. An important step in this direction is an improvement in the training and conditions of service of vaccinators in many provinces. The number of vaccinators employed will have to be increased adequately and, basing our recommendations on data available from Madras, we have indicated how other provinces may institute an effective campaign of primary vaccination and revaccination.

### CHOLERA

136. Cholera is another preventible disease which takes a heavy toll of life in the country and shows a wide range of variation in its incidence from year to year. Some idea of this range of variation may be obtained from the cholera mortality figures for the province of Madras in 1939 and 1943. In the former the total deaths from the disease numbered about 2,000, the lowest incidence recorded for 60 years. In 1943 it spread to every district in the province and the registered mortality from this cause was 117,000. The incidence of cholera varies from province to province, those in which its prevalence is high being Bengal, Madras, Bihar and the Central Provinces and, to a smaller extent, Orissa and the United Provinces.

137. The measures required for the control of the disease fall broadly into two groups, (a) those which are permanent and (2) those which are of a temporary nature. The former include the following:—

- (1) the provision of protected water supplies;
- (2) the satisfactory disposal of nightsoil so as to prevent the possibility of contamination, by infective material, of food and water supplies and
- (3) sanitary control over the production, distribution and sale of food.

In regard to each of these the position in India today is far from satisfactory. Protected water supplies are available only in the larger towns and cities and they serve only small proportions of the population in individual provinces. Provision for the proper collection and disposal of nightsoil is quite inadequate in rural areas and in the majority of urban centres, including many towns and even certain cities. The sanitary control exercised over the production, distribution and sale of food leaves much to be desired in all parts of the country.

138. Anticholera measures of a temporary nature are of special value when an outbreak of the disease takes place. These include:—

- (1) isolation and treatment of patients;
- (2) disinfection of infective material and
- (3) immunisation of the people by anticholera inoculation.

As regards (1) and (2) above little or no effective action is being taken in most parts of the country, particularly in the rural areas. Isolation hospitals are few in number and even those that exist are far from satisfactory as regards their staffing and equipment. As regards anticholera inoculation, the popularity of this measure has been a process of steady growth. The people have come to recognise its value and are, broadly speaking, willing to accept inoculation when an outbreak of the disease takes place.

### **Our Recommendations**

139. *Permanent measures.*—We have suggested, in the chapters dealing with water supply and general sanitation, comprehensive programmes of development of urban and rural water supply and night-soil disposal systems. In providing these basic facilities for sanitary improvement, Provincial Governments should direct that, in fixing priority, consideration should be given to the incidence of cholera in individual towns and villages. In this way, the main centres of cholera prevalence can be brought under effective control and the spread of the disease from such sources of infection prevented. Simultaneously with these improvements the gradual extension, over the country as a whole, of the health organisation we have recommended should help to introduce a large measure of control over the food of the people so as to ensure freedom from contamination. There will also be a rise in the general level of environmental hygiene. The combined effect of all these measures is bound to be a marked reduction in the incidence of cholera and other bowel diseases.

140. *Temporary measures.*—The temporary measures we have indicated above should be carried out by the primary unit staff as effectively as possible. The active assistance of the members of the Village Health Committees would prove invaluable in enforcing these measures.

### **Pilgrim Centres**

141. Pilgrim centres have, in the past, played an important part in the spread of cholera. The adoption of special measures for safeguarding the health of pilgrim centres has now become an established practice in the country. In addition it has been found useful to enforce the compulsory inoculation of persons against cholera before they are permitted to attend such festivals. At the instance of the Central Advisory Board of Health this measure has been carried out by a certain number of Provincial Governments in selected festival centres with encouraging results. The adoption of this measure on a wide scale should prove to be an additional precaution against the possibility of outbreaks of cholera starting in festival centres.

## **PLAGUE**

142. The history of plague in recent times dates from 1896 when it was introduced into the seaport of Bombay from China and spread

rapidly over very large parts of the country. In 1904 deaths from this disease reached the very high figure of nearly 1,150,000. Since then there has been a considerable reduction in the incidence of plague, the average annual mortality from this cause during 1939-41 being only about 19,350.

143. Plague is primarily a disease of certain rodents and human infection on an appreciable scale takes place only under conditions favouring close association between man and such rodents. In India the animal is the rat while, in other countries, the reservoirs of plague infection are certain other rodents. Man becomes infected from such animals through the bite of the fleas which live and feed on these animals.

144. Plague appears in two forms, bubonic and pneumonic, the latter being the more severe of the two. The rate of mortality in bubonic plague may be as high as 60 to 70 per cent among those who are attacked, while that for pneumonic plague is practically cent per cent.

145. Although the incidence of the disease has become very much reduced within recent years, the Director of the Haffkine Institute, Bombay, has pointed out that certain endemic areas exist in different parts of the country and that they constitute a constant threat in as much as, under favourable conditions, plague may spread from these centres to other parts of India. These centres are situated in cool and moderately damp areas from the Himalayas in the north through Central and Eastern India to the Deccan and the province of Madras.

#### **Our Recommendations**

146. The measures against the disease should mainly be directed against the rat as the primary reservoir of infection from which the disease spreads to man. The keeping down of the rat population in inhabited areas, particularly in the endemic centres of plague, is therefore an important preventive measure. Rats grow in numbers in human dwellings only when they can secure food and adequate protection. The elimination of these conditions is therefore the purpose to be kept in view. The systematic destruction of rats by various methods is also another important measure which should be generally adopted.

147. The steps to be taken for rendering the conditions in residential areas unfavourable to the growth of the rat population include (a) the construction of rat proof dwellings and rat proof grain stores and railway godowns, (b) control over the location of certain trades and industries which attract rats and (c) an improvement of the general sanitary condition of the towns and villages, as the throwing of garbage in public places encourages the breeding of rats by providing them with food. Our recommendations cover all these steps.

#### **Treatment of Plague**

148. Till recently, there was no specific treatment for plague and the efforts of the physician were mainly directed towards giving relief to the patient and to the keeping up of his strength. A few years ago the Director, Haffkine Institute, prepared a serum which, on field trial, was established to be definitely more effective than the ordinary form of treatment. Sulphapyridin and sulphathiazole have also been

found to be useful in the treatment of plague. Of the two, sulphathiazole is considered the better drug because its effectiveness is probably a little higher and its toxicity less.

## LEPROSY

149. The number of persons suffering from leprosy in the world has been estimated as somewhere about five millions and, of these, leprosy patients in India are believed to be at least a million. "There is a belt of high incidence including the whole of the east-coast and the south peninsula, including West Bengal, South Bihar, Orissa, Madras, Travancore and Cochin. In the central parts of India the incidence tends to be lower but there are some foci of higher incidence. There is a belt of moderate incidence in the Himalayan foot hills, running across the north of India, while in most of the north-west of India there is very little leprosy."\*

150. In the highly endemic areas its incidence may range from two to five per cent of the population and, in restricted areas, it may even be as high as 10 to 15 per cent. In the non-endemic regions of North-Western India, on the other hand, large areas may show no cases at all while the general level of incidence is stated to be as low as 0.01 per cent or one per ten thousand of the population.

151. Cases of leprosy are broadly divided into two groups, the "neural" and "lepomatous" types. The former constitutes the "benign" form of leprosy and the other the more severe and infectious type. While for the country as a whole the proportion of lepomatous cases is estimated at about 20 per cent of leprosy patients, there are areas where the proportion of this severer type is as low as 4 per cent and others in which it rises even to 50 per cent. In estimating the importance of leprosy as a public health problem the rate of incidence and the relative proportion of the lepomatous type should both be taken into consideration.

### Our Recommendations

152. In order to promote antileprosy work on proper lines we put forward the following proposals for the short-term programme:—

- (a) the creation of provincial leprosy organisations;
- (b) an increase of the existing provision for institutional treatment of out-patients and in-patients;
- (c) development of group isolation colonies;
- (d) substantial financial help to voluntary organisations engaged in antileprosy work and
- (e) the establishment of a Central Leprosy Institute.

### The Provincial Leprosy Organisation

153. As a preliminary step towards organising antileprosy work on sound lines a leprosy organisation should be created at the headquarters of each province, in which the disease is a definite public health problem, this organisation being made an integral part of the provincial health service. At its head will be the Provincial Leprosy

\* Report on Leprosy and its control in India (1941) by the Special Committee appointed by the Central Advisory Board of Health.

Officer, who will be responsible for organising antileprosy work in all its branches.

### **An Increase of the Existing Provision for Institutional Treatment**

154. The leprosy clinic is an important link in the chain of measures for the control of the disease and it should perform the dual role of providing remedial and preventive care to the people in the same manner that the tuberculosis clinic does in the campaign against that disease. A start should be made by providing a properly equipped and staffed leprosy clinic in association with every secondary health centre hospital. Existing leprosy clinics require to be staffed and equipped properly in order to improve the quality of the work that they are doing.

155. Existing provision for the isolation of leprosy patients is limited to about 14,000 beds, while infective cases requiring isolation may well be about a quarter of a million. We propose that, in the first five years of our programme, an additional 14,000 beds should be provided and that, in the next five years, an equal provision of another 14,000 beds should also be made.

### **Development of Group Isolation**

156. An adequate expansion of institutional facilities so as to provide for the isolation of all the infective patients in the country can hardly be expected to materialise for a very long time to come. The possibility of developing group isolation therefore requires serious investigation. Certain points to remember in this connection are that the period of isolation will be long, perhaps years, that provision should be made for medical care although it may not be of a very high standard, that the scheme, if it is to be widely adopted, should be sufficiently cheap to suit the economic level of the country and that provision should be made to promote corporate life in the isolated community and to enable the more able-bodied members of it to work and contribute towards the maintenance of the colony.

157. Certain experiments for developing isolation colonies have already been carried out in this country and are being projected in the near future. Local conditions vary considerably in different parts of the country and we consider that group isolation colonies should be developed in all the more important areas where leprosy is a health problem. We have suggested an annual expenditure of Rs. 3 lakhs on the development of such colonies during the first ten years.

### **Financial Help to Voluntary Organisations**

158. Missionary bodies have so far contributed much more to the development of antileprosy work in India than public authorities. For instance, it is understood that a little over 10,000 beds out of a total of 14,000 in the country are maintained in missionary institutions. In addition to a wide expansion of measures against the disease under the auspices of the Governments and of local health authorities, it will be necessary for voluntary effort to continue unabated in this field and we have therefore recommended provision to the extent of Rs. 187.5 lakhs during the first ten years to subsidise such effort.

### **The Central Leprosy Institute**

159. We consider it necessary that a Central Leprosy Institute should be established, its main functions being (1) the training of

leprosy workers, (2) the active promotion of research in the subject and (3) the development of an information service providing the latest information regarding the treatment of the disease and antileprosy work in general for the benefit of Governments and organisations interested in leprosy in India.

## VENEREAL DISEASES

160. The incidence of venereal diseases in India is unknown. A survey (the results of which were published in 1933) by Sir John Megaw, a former Director General of the Indian Medical Service, regarding the incidence of syphilis and gonorrhoea in this country showed that the rate of their total incidence was somewhere near 37 per 1,000 of the population. This is a sufficiently high figure to point to the urgent need for fuller investigation as well as for the starting of a campaign against them on as extensive a scale as circumstances would permit. Their importance from the point of view of producing sickness and incapacitation cannot be over-emphasised. Both syphilis and gonorrhoea are responsible for much blindness. Of the two, syphilis is the more important. If not treated in time and adequately, it produces degenerative changes of a varied character in the internal organs of the body and, in a certain number of cases, it also causes the condition known as the general paralysis of the insane. The disease is transmissible from parent to offspring and is responsible for a considerable proportion of the abortions and premature births that take place. Syphilis accounts also for a large amount of mental deficiency. Gonorrhoea, in its turn, contributes to ill-health through joint troubles and various conditions affecting the genito-urinary organs in both sexes. In women it may produce sterility.

### Our Recommendations

161. The measures which are necessary for the control of these diseases may be divided into two broad groups, namely, (1) those which provide the best available forms of medical care, preventive and curative, and (2) those which are designed to discourage promiscuity and to control prostitution.

162. Our recommendations under (1) include the provision of free and confidential treatment to all persons seeking such treatment, of facilities without payment of fees for personal prophylaxis and of adequate facilities for the diagnosis of these diseases as well as the creation and maintenance of a follow-up service and educational work among the people in regard to their spread and control.

163. Measures designed to discourage promiscuity in the community and to control prostitution are obviously more difficult to devise and enforce than the medical measures recommended above. Education in a wide sense of the term, so as to promote the growth of the individual's moral sense and of his responsibility towards himself and the community, and sex education intended to create a correct appreciation of the problems of sex relationship and to impart knowledge regarding the spread of venereal diseases and the dangers that arise from them, must together provide the conditions essential to secure the success of any attempt to control indiscriminate sexual intercourse, whether it be in the restricted field of prostitution or

outside it. We have proposed the gradual provision of sex education to all sections of the community, such provision starting first with teachers in training schools and colleges and, through them, extending to school children and college students. Steps for controlling prostitution are also suggested. These include the enforcement of severe penalties on those who keep brothels and on landlords who promote the use of their premises for this purpose. As regards the prostitute, our recommendations are intended to provide her with adequate medical treatment for venereal diseases as well as to help her, through educative work, to return to the normal mode of life.

### HOOK-WORM DISEASE

164. The hook-worm produces its harmful effect on the human host by the loss of blood it causes through feeding on him, by irritation of the bowels which it produces and the resulting disturbance of the digestive function and by the secretion of a poisonous substance which prevents the clotting of blood and thus promotes bleeding. The disease is widely prevalent in India. The labour populations in Assam and certain parts of South India and of the plantations in Coorg are heavily affected as well as the general population of certain parts of Travancore, Malsbar and South Kanara. Varying intensities of infestation are found in the provinces of Bengal, Bihar, Orissa, the eastern portion of the Central Provinces, some parts of the United Provinces and the Punjab and on the east coast of Madras. The North-West Frontier Province, Rajputana, Sind, Kathiawar, Central India States, Hyderabad, Deccan and Mysore State are practically free.

165. Our recommendations regarding the provision of adequate arrangements for nightsoil conservancy in rural and urban areas will, if implemented, constitute an important step towards the control of hook-worm disease. Soil pollution through human excreta and the habit of walking barefoot constitute the two main factors responsible for its spread. What is therefore needed is that the people should be taught how to render these factors inoperative. The health education campaign, which we hope will be conducted in the schools and colleges and among the general population as an essential part of our programme, should help materially towards this end. In the meantime mass treatment, by the administration of the appropriate drugs, should be carried out among the heavily infested groups of the population. The simultaneous development of a system of nightsoil conservancy for such communities, on lines suited to local conditions, is also necessary.

### FILARIASIS

166. The disease leads to the permanent swelling of the legs and certain other parts of the body, besides causing recurring attacks of fever and inflammation of the lymphatic system. It is responsible for a considerable amount of preventible suffering and disability, although it does not cause death.

167. Bengal is the most heavily affected province in India. The incidence of filariasis is high in the western districts of this province and its intensity gradually decreases eastwards and northwards. The

Chittagong Hill Tracts and the northern districts of Jalpaiguri and Darjeeling are free. In Assam the disease is present in many districts, although its intensity is lower than in Bengal. In Bihar its incidence is relatively high in the Gangetic plain and in Orissa in the coastal districts. In Madras areas of moderate prevalence exist in the districts of Tanjore, Kistna, Godavari and Vizagapatam and in Saidapet near Madras City, while the coastal tracts of Malabar and South Kanara districts and of the Indian States of Travancore and Cochin show areas of high incidence.

168. Extended research has failed to produce a satisfactory cure for this disease. The only effective measures against it known at present are those which are concerned with the control of the carrier species of mosquito. In the affected areas it is therefore essential that adequate control measures should be undertaken in order to secure an effective reduction in the mosquito population.

### GUINEA-WORM DISEASE

169. Guinea-worm disease is widely prevalent in certain districts of the North-West Frontier Province while its incidence is relatively low in the Punjab. The Rajputana desert is free but many of the States in Rajputana and Central India contain heavily infected areas. In the Central Provinces, Bombay Presidency, the Nizam's Dominions and Madras Presidency the disease is prevalent over wide areas. Well watered tracts, with a fairly heavy rainfall such as Bengal, are generally free.

170. The prevalence of the disease is dependent on opportunities for the infection of water supplies by persons harbouring the worm. In the affected areas step wells, tanks and other sources of water liable to contamination are responsible for keeping up the infection and the application of lime to such water supplies has been shown to be effective in sterilising them.

### CANCER

171. Such evidence as is available seems to suggest that the relative incidence of cancer in India is probably as high as in western countries. As regards the causative factors "whether it be the cervix, the oral cavity, the penis, the skin or the gastro-intestinal tract, the factor of irritation seems to excel all other possible causes and brings the problem of this fell disease within the scope of preventive medicine."

172. Our proposals for the short-term programme are:—

- (1) Provision for radium and for deep x-ray treatments should be made, in addition to existing centres for such treatments, at all the hospitals associated with the present medical colleges and with those which will be established during the short-term programme. The centres at which such facilities are now available are shown in Appendix 20 of Volume III of the report.
- (2) In addition to the Tata Memorial Cancer Research Hospital at Bombay, three more institutions for promoting advanced research and teaching in the subject are



needed to serve North-Western, Eastern and Southern India respectively.

- (3) A considerable extension of diagnostic facilities will be necessary. The laboratories attached to the secondary unit hospitals, the provincial public health laboratory organisation with its regional branches, which we have recommended in the chapter on medical research, and the special institutes referred to above should all help to provide this extended service.

### MENTAL DISEASES AND MENTAL DEFICIENCY

173. Conditions of mental ill-health may be divided into two broad groups, (1) mental disorder and (2) mental deficiency. The former may be either inherited or acquired and very often it is both. No age is exempt from mental disorder, although the types may vary at different age periods. A large proportion of these patients is amenable to modern methods of treatment.

174. Mental deficiency is ascribed, on the other hand, to a hereditary or congenital taint or to some accident or illness occurring just before or soon after birth. Although the condition is generally regarded as incurable, by proper care and supervision the majority of defectives can be made to lead useful but segregated lives, and they can also be prevented from becoming criminals and, in the case of girls, social menaces.

175. In England and Wales there were, at the beginning of 1937, about 129,750 patients under treatment in mental hospital, a proportion of 3.2 mental patients per thousand of the population. In America, the annual admission rate has varied from 5 to 8 per thousand in different years and in different States. In India there is no reason to believe that the rate of incidence of mental diseases is in any way less than those for England and the United States. While certain factors which are operative in those countries may not affect India to the same extent, other factors such as chronic starvation or under-nutrition, tropical fevers, anaemias and frequent childbirth in women, who are unfit for motherhood, are responsible for large numbers of mental breakdown in this country. In view of these considerations, even if the proportion of mental patients be taken as 2 per thousand of the population in India, hospital accommodation should be available for at least 800,000 mental patients as against the existing provision of a little over 10,000 beds for the country as a whole. In India the existing number of mental hospital beds is in the ratio of one bed to about 40,000 of the population (taking the present population of the country as 400 millions) while, in England, the corresponding ratio is approximately one bed to 300 of the population.

176. As regards the possible numbers of persons suffering from varying degrees of mental disorder, who may not require hospitalisation and yet should receive treatment, and of those suffering from mental deficiency, it seems almost certain that the numbers are likely to run into several millions in this country, if the rate of incidence in England or America can be taken as even an approximate guide for making estimates for India.

### Our Proposals

177. As against this background of mental ill-health the existing provision for the medical care of such patients is altogether inadequate

and unsatisfactory. We therefore make the following recommendations for the short term programme:—

- (a) the creation of mental health organisations as part of the establishments under the Director General of Health Services at the Centre and of the Provincial Directors of Health Services;
- (b) the improvement of the existing 17 mental hospitals in British India and the establishment of two new institutions during the first five years and of five more during the next five years;
- (c) the provision of facilities for training in mental health for medical men in India and abroad and for ancillary personnel in India and
- (d) the establishment of a Department of Mental Health in the proposed All-India Medical Institute.

178. (a) *The creation of mental health organisations as part of the establishments under the Director General of Health Services at the Centre and of the Provincial Directors of Health Services.*—The creation of mental health organisations as part of the establishments of the Director General of Health Services at the Centre and of the Provincial Directors of Health Services is, in our view, of such great importance that we have placed it first among our recommendations. So little information is available regarding the incidence of mental ill-health in the country and the developments in this field of health administration, even in the more progressive countries, are so recent that we feel we shall not be justified in attempting to make detailed recommendations regarding the mental health organisation which the country requires. We must leave this task to the health departments with the guidance of the specialists, whose appointment we have suggested.

179. (b) *The improvement of the existing 17 mental hospitals and the establishment of two new institutions during the first five years and of five more during the next five years.*—Radical improvements should be made in the existing mental hospitals in order to make them conform to modern standards. Provision should also be made for all the newer methods of diagnosis and treatment. Apart from such remodelling of existing mental hospitals we recommend the creation of 7 new institutions during the short-term programme, of which at least two should be established as early as possible during the first five-year period.

180. (c) *The provision of facilities for training in mental health work for medical men in India and abroad and for ancillary personnel in India.*—Nowhere in this country are available all the facilities necessary for the starting of a course for the Diploma in Psychological Medicine. We recommend that, as early as possible, courses of training for this Diploma should be developed in Bombay and Calcutta in association with the universities concerned. We also suggest that, as soon as possible, similar diploma courses should be developed in the universities of other provincial capitals. In the meantime a certain number of carefully selected medical men, with some experience of work in mental hospitals in India, should be sent abroad for training. Provision should be made for sending at least

20 doctors during the first five years and another 20 during the second five years of our programme.

We have also made proposals for developing training facilities for non-medical mental personnel, including such workers as occupational therapists, psychiatric social workers, psychologists, nursing staff and male and female ward attendants.

181. (d) *The establishment of a Department of Mental Health in the proposed All-India Medical Institute.*—This Department is calculated to promote (1) the development of facilities for the undergraduate and postgraduate training of doctors in all branches of psychological medicine and the demonstration to the provincial authorities of the standards to be aimed at when similar facilities are created by these authorities in their own territories, (2) the promotion of research in the field of mental health and (3) participation in the organisation of a mental health programme for the area in which the Institute is located.

### ENVIRONMENTAL HYGIENE

182. Under this head we deal with the subjects of (a) town and village planning, (b) housing, rural and urban, (c) water supply, (d), general sanitation, including conservancy and drainage, (e) river and beach pollution, (f) control of insects, rodents and other vectors of disease and (g) control of trades dangerous and offensive to the community.

### TOWN AND VILLAGE PLANNING

183. Most of the populated rural and urban centres in the country have grown up in the past without due regard to the principles of planning. In the postwar period new large scale industrial developments, the execution of large public works and other activities will, in all probability, help to create new townships and settlements and thus further the process of urbanisation. It is, therefore, essential to regulate the growth of towns in accordance with the principles of sound town planning, to make a determined effort to eradicate existing slums and to prevent conditions in which they can again grow and thrive.

### Our Recommendations

184. (1) A Ministry of Housing and Town and Village Planning should be established in each province as only in this way can the subject receive the attention which it demands. At the centre we are not suggesting the creation of such a Ministry because the direct responsibility for planning and execution will rest with Provincial Governments. But there should be at the Centre an expert in town planning who, for the purpose of administration, may be attached to the establishment of the Director General of Health Services under the Ministry of Health. This officer should be the consultant to other departments of Government such as the Railways and Posts and Telegraphs. All requests from the provinces for financial support from the Centre in respect of their town and country planning schemes should be scrutinised by him from the technical point of view. The Central Directorate of Town and Village Planning should also function as an information bureau for town planners throughout the country.

185. The Provincial Ministry of Housing and Town and Village Planning should have a technical expert as its adviser, who may be called the Director of Town and Village Planning, with suitable subordinate staff under him. All local authorities, improvement trusts, building societies, industrial organisations, private estate development concerns and government departments should submit their schemes for such development or slum clearance, if they come within certain prescribed standards, to the Provincial Ministry of Housing and Town and Village Planning for previous sanction. The Director of Town and Village Planning will be responsible for the technical scrutiny of all these schemes.

### **Town and Village Planning Legislation**

186. Legislation to regulate planning in respect of towns exists in the provinces of Madras, Bombay, the Punjab and the United Provinces. But, as far as we are aware, no such provision exists in respect of rural areas. We consider that legislation should be enacted in all the provinces on a fairly uniform basis and that it should include, within its scope, both urban and rural areas. We therefore suggest that the Central Government should, in consultation with town planning experts, draw up model legislation and recommend its adoption by the provinces or, with their approval, secure the enactment of an all-India measure. In either case, the proposed legislation should include all the requirements that modern conceptions regarding town and village planning would suggest for incorporation.

### **Planning in Urban and Rural Areas**

187. *Large cities.*—In some of the larger and more congested cities in India improvement trusts have been engaged, for some time, in slum clearance and the improvement of housing. The results have not, however, been satisfactory in a number of cases, because cleared areas resulting from costly demolition operations have been allowed to be built over without adequate control. The existing legal and administrative procedure should, where necessary, be so modified as to ensure that such undesirable developments are not permitted to continue. We recommend that improvement trusts should be established in all the larger cities of the country for dealing with slum clearance and rehousing problems. One of the handicaps from which existing improvement trusts suffer is lack of technical assistance. Every trust should be required to employ a town planner on its staff as soon as trained personnel of this class becomes available in sufficient numbers.

188. *Other urban areas.*—The urban areas for which the establishment of improvement trusts is likely to be considered not feasible will, from the point of view of size and importance, be such as to make them suitable for inclusion in the district health organisation we have proposed earlier. The local authority that should be made responsible for the planning of such urban areas should be the District Health Board. This authority should, as in the case of an improvement trust, be required to maintain on its establishment a trained town planner.

189. *Rural areas.*—In the early stages of our programme it will be difficult to extend planning operations into the rural areas as a whole. During this period, attention may be confined to the lay-out

of new villages which may be established as the result of developments in industry, mining, agriculture or the settlement of demobilised personnel. In the case of all new villages, the Provincial Director of Town and Village Planning should be consulted beforehand by the department concerned and he should design the lay-out.

### **Location of Industry**

190. The haphazard location of industries in inhabited areas must be controlled by proper legislation. Legal provision exists in certain provincial Local Self-government Acts for enabling the local authority to regulate their location within their areas. We desire to see adequate provision for controlling the location of industry included in the proposed model legislation for town and village planning. Our suggestion that the lay-out of any new industry should be submitted to the Ministry of Housing and Town and Village Planning for previous approval should also apply to residential accommodation provided for industrial workers. A colony for such workers should not be permitted on a temporary basis for a longer period than three years and, even during this period, adequate provision should be made for such amenities as roads, water, drainage, sanitation and lighting.

### **Training Facilities for Town Planners**

191. We make two recommendations. One is that a certain number of selected individuals should be sent to Europe and America for training in the subject. The other is that town planning experts from abroad should, if necessary, be recruited on short-term contracts and that training centres should be set up at least in a few universities in the country.

## **HOUSING, RURAL AND URBAN**

192. Housing conditions in India present a deplorable picture. The impressions that we gained during our tours indicate extremely unsatisfactory conditions of housing in some rural and urban areas and, in particular, appalling conditions of overcrowding in industrial centres. The single room tenement is a common feature of even many of the more recently constructed housing accommodation in industrial areas. Such tenements often house more than one family and, in any case, have to serve as living room, kitchen and bed room. The sanitation of these dwellings is usually inadequate and of a very rudimentary nature. Thousands of workers have been drawn to these industrial centres by new war industries or by the expansion of old ones, but little attempt has been made to provide the additional accommodation required. The result is that conditions in Calcutta, Bombay, Madras and Cawnpore, to mention only a few cases, are indescribable and intolerable. Thousands are without any home or shelter and have to live and sleep on pavements, verandahs, open spaces, under trees, in cow sheds or in any temporary shelter.

### **Recent Housing Developments in Western Countries**

193. Between the two world wars the provision of adequate housing for the people was recognised in most European countries as an urgent and important social problem and Governments accepted the view that "housing has become a public utility" and that "the right to live in a decent dwelling has taken its place in the "national minima"—the right to good and abundant water, to sanitation, to

adequate fire and police protection, to the use of paved and lighted roads, to education, to a certain amount of medical care, and, in most European countries, to various forms of social insurance". These national housing schemes have certain features which include control by the public authority over housing standards and financial aid directed towards promoting the building of houses of the required quality and in sufficient numbers, and the maintenance of the scales of rent at reasonable levels.

### **Our Recommendations**

194. In India a long-term policy, comprehensive in scope and modern in outlook, is essential for a satisfactory solution of the housing problem. The objective to be attained is the creation of hygienic houses in adequate numbers and of adequate size, in "sanitated" areas equipped with all the facilities necessary for community life. In the execution of the housing programme Governments and public authorities should perform the following functions:—

- (i) the planning, execution and regulation of housing programmes, including participation by local authorities and improvement trusts in house construction and maintenance;
- (ii) the grant of financial assistance by long-term loans at low rates of interest, or grants-in-aid;
- (iii) the prescription and enforcement of standards and
- (iv) the promotion of housing research.

195. *Functions of the Provincial Governments.*—Upon Provincial Governments must rest the primary responsibility for dealing with housing and town and village planning. The housing of the people is essentially a State responsibility. It may, of course, be delegated under suitable conditions and in defined areas, to local bodies or public authorities such as improvement trusts. Elsewhere it will be necessary to utilise every available agency if a comprehensive programme is to be planned and executed within a reasonable time. Provincial Governments should consider the establishment of a statutory body, under the direction and control of the Ministry of Housing and Town and Village Planning, with financial resources and power to plan and execute a province-wide house construction and town and village development programme on a 20—30 year plan, in five yearly stages. The Provincial Ministry of Health is deeply concerned in the proper execution of any housing schemes and should be responsible for the control and enforcement of minimum standards in the design and construction, not only of houses but also of environmental amenities, such as water supply, sanitation and recreation. The two Ministries must work in close co-operation with one another and the staff of the Ministry of Health must, at all stages, be in contact with those who are responsible for the execution of housing schemes and town and village planning.

196. *Functions of the Local Authority.*—Our recommendations for provincial and district health administration will, if implemented, establish certain new local authorities in the place of existing ones. We visualise the creation of separate district organisations to deal with health, education, public works and communications, in order to provide more favourable conditions for efficient administration. In

carrying out a province-wide housing and planning policy in urban and rural areas, the work of enforcement of standards, from the health point of view, will fall upon the district health organisation and its officers. On the other hand, the actual construction and maintenance of housing colonies will be carried out by the district agency which deals with public works and which, in this connection, will be under the control of the Ministry of Housing and Town and Village Planning or the authority to which the Ministry has delegated its powers.

197. *Housing standards.*—We have set out certain general recommendations regarding the minimum standards to be prescribed for all houses built under public or private auspices. For details regarding these standards reference may be made to paragraphs 25 to 33 of chapter XIII of Volume II of our report.

198. *Type plans.*—The legal enforcement of housing standards is only one method of approach towards raising the quality of construction. Type plans and estimates covering a considerable range of cost, material and sizes should be prepared. These plans and estimates should be based on local rates of cost, as far as possible, and should incorporate locally procurable material and they should be made readily available to the general public.

### **Housing for the Lower Income Groups**

199. We believe that an India-wide housing programme should give first priority to the needs of the lower income groups of the population. It is not easy to fix an upper limit of income suitable for all provinces. In the South it might be Rs. 100 to 150 a month and in the North Rs. 150 to 250. The limit would have to be fixed by each Provincial Government.

200. *Urban areas.*—In many towns and cities industrial workers live interspersed with the general population and the housing problem must therefore be considered for the community as a whole and not for industrial workers only, bearing in mind the income levels we have suggested for defining the working class population. We believe that future developments in the housing sphere will be regulated on proper lines if such developments are undertaken under public auspices, particularly in the larger urban centres. We have already said that the responsibility for providing houses for the people rests on the Governments of the country. Local authorities and industries should, no doubt, bear their share of the cost, but the State cannot escape the fundamental responsibility.

201. *Rural areas.*—The housing problem in rural areas presents special difficulty. The Governments concerned, through such local authorities as may be suitable, should be responsible for enforcing minimum standards in any new village construction. They should also assist, with finance, advice and example, in the improvement of existing houses in rural areas. Type designs for new houses and suggestions for the improvement of existing ones should be made available to the villagers through the Health and other appropriate Departments. As in the case of housing in urban areas, Governments should be prepared to finance or assist in financing any approved schemes for new housing or housing improvement, whether sponsored by the Governments themselves, by local authorities, by co-operative banks or societies or by private interest. Governments must, however, exercise control over the planning and execution of

such schemes and, in particular, over the rents to be charged for new houses and any increase in the existing rents in the case of housing improvement.

### WATER SUPPLY

202. According to the 1939 report of the Public Health Commissioner with the Government of India only 253 towns out of a total of 1,471 towns of all sizes in British India possessed protected water supplies. The population served by these was about 12.7 millions or 48.7 per cent. of the aggregate population of all the towns, but only 4.5 per cent. of the total estimated population of British India in that year.

Rural water supplies are drawn mostly from wells, tanks, rivers and streams and they are almost completely unprotected.

#### Our Proposals

203. A vigorous policy should be adopted immediately by Governments for the development of a water supply programme, which should aim at providing the entire population under their charge with safe water for drinking and domestic purposes within a period of about 35 years. The initiation of the scheme should not be left to local authorities and sufficient funds should be made available to complete the programme within this period. Technical bodies, which may be designated Central and Provincial Water and Drainage Boards, should be established in order to assist Governments in the planning and execution of water and drainage schemes on a comprehensive scale.

204. *Functions of Water and Drainage Boards, Central and Provincial.*—The Central Board will perform the dual task of carrying out, in the Central Administered Areas, the same duties which the Provincial Board will perform in its own territory as well as of dealing with various matters of interest and importance to more than one province, such as the conservation of water on an all-India basis and inter-provincial problems of drainage and river pollution. In addition, the Central Board will assist the Central Government in carrying out its general policy of promoting co-ordinated effort in the provinces and of giving financial aid and technical advice in the furtherance of their water and drainage schemes.

205. The more important among the functions to be performed by the Central and Provincial Boards in their respective areas include (1) the conservation of the available sources of water in their respective territories and its allocation to the different needs of the community, (2) the general planning of water supply and drainage schemes and the preparation of a priority list in respect of such schemes, (3) various technical matters such as the standards to be prescribed for the purification of water and sewage, the training and registration of water operators and the investigation of special local problems such as the purification of trade wastes, removal of fluorides, etc., and (4) the recommending of grants to the Governments concerned for water and drainage schemes.

#### Water Conservation on an Inter-provincial Basis

206. The importance of this question was forcibly brought to our notice by the Superintending Engineer, Public Health Engineering Department, the United Provinces. He said "the depletion of the main rivers in this province, particularly the Jumna and the Ganges,



by the wholesale extraction of large quantities of water by the Irrigation Departments of the Punjab and the United Provinces, has had very serious repercussions on the water supply of several large towns in this province, particularly Agra and Cawnpore." He also pointed out that it has aggravated another problem, namely, large scale river pollution from trade wastes.

207. The question of conserving all the available sources of water throughout the country and of so allocating the supply, from a common source, to meet the reasonable demands of individual provinces concerned, is of paramount importance from the standpoint of the health and general welfare of the people and we have come to the conclusion that this matter calls for special consideration. Where an urgent decision on such a matter is required, the Central Government should be empowered to give a temporary decision which should be binding on the provinces concerned, until a final settlement is reached through the award of an Arbitration Board or any other suitable body to which reference should be made with the least practicable delay. We consider that the same procedure should apply to inter-provincial problems of river pollution by trade wastes and sewage. Even when an urgent decision has to be taken by the Central Government we consider it necessary that such decision should be taken only after consulting the Central Water and Drainage Board and the Central Board of Health in regard to the technical and administrative aspects of the question.\*

208. As regards the other subjects included under the heading "Environmental hygiene" such as general sanitation, river and beach pollution, control of insects, rodents and other vectors of disease etc., we have set out detailed proposals in the relevant portions of chapter XIV of Volume II. These, if implemented, will, it is anticipated, make for a considerable improvement of the existing unsatisfactory state of affairs.

## QUARANTINE

### International Quarantine

209. As regards international quarantine two aspects require consideration. One is prevention of the export of infection in respect of the diseases recognised under the International Sanitary Conventions and the other is that of protecting India from the possible introduction of diseases such as yellow fever, sleeping sickness and others from which the country is at present free. In regard to both the measures now enforced in India are considered reasonably complete and satisfactory.

210. The ratification of international treaties should be one among a small group of subjects in respect of which the Centre should be given the power to compel a province to fall in line with the other provinces. The fact that international air lines pass through different provinces in the country necessitates action on common lines in respect of the health requirements of airports and their surrounding

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\*Mr. P. N. Saprú does not agree with the above recommendations for dealing with these difficult problems. He has dealt with his view in a note which is appended to chapter XIV of Volume II of our report. The views of the rest of the Committee on Mr. Saprú's note will be found in paragraph 22 of the same chapter.

areas and it is therefore essential that the Central Government should be able to carry out a common policy throughout India.

### Internal Quarantine

211. Internal quarantine is concerned with the enforcement of measures designed to control the spread of infectious diseases between neighbouring units of administration, namely, the provinces and Indian States. We make the following recommendations:—

212. (1) The Central Government should be responsible for the enforcement of all measures necessary to prevent the inter-provincial spread of infectious disease. In this connection India may well follow the practice which is in existence in the United States of America. In that country "the Federal Health Service has control of sanitation in interstate traffic" including supervision of the sanitary facilities on all interstate vehicles. The Federal Government also assists the States in the control of communicable diseases within their own territories, if desired to do so. The Central Government in this country should be similarly empowered to control the inter-provincial spread of epidemic diseases.

213. (2) The Central Board of Health should draw up, in consultation with the health advisers at the Centre and in the Provinces, a memorandum of instructions to be followed by the Central and Provincial health departments in order to promote the effective control of the spread of infectious diseases. The whole field of possible co-operation should be examined on a wide basis and a common programme of action drawn up under the auspices of the Board.

214. (3) The desirability of creating an inter-provincial fund for carrying out the measures outlined above should be considered, the Central and Provincial Governments making their contributions to this fund on some agreed basis. Such a fund will also constitute an insurance for all Governments against possible disasters such as famines, floods and earthquakes.

215. (4) The measures described above for the enforcement of internal quarantine can hardly be effective without the active participation of Indian States. Such participation can be of value only if those States possess a reasonably good health organisation. The more important of the States probably satisfy this condition. If, in the beginning, even these can be brought into the scheme by mutual arrangements between British India and the States, the range of activity of the internal quarantine organisation and its effectiveness will have been greatly increased.

### VITAL STATISTICS

216. Errors in existing vital statistics in India fall under three heads, (1) incompleteness in the recording of the events, (2) inaccuracy of the registered cause of death and (3) faulty compilation. Registration of vital statistics in all municipalities is, generally speaking, a function of the municipal public health department. In the rural areas, in most provinces the Registrar is the police officer in charge of the *thana* (police station) and the person responsible for reporting births, deaths and cases of notifiable diseases from individual villages is the *chowkidar*, who is perhaps the lowest grade of public servant and is generally illiterate. In the province of Madras the Registrar is the headman of each village.

217. The recorded vital statistics are passed on, through a series of officers, to the Director of Public Health in each province. Compilation of the data is carried out at the different stages of transmission. Madras forms an exception to this general statement. Here the number of intermediary stages has been reduced, the village headman passing on his report to the *Tahsildar* of the *taluk* in which the village is situated and the latter sending it directly to the Director of Public Health. Compilation of the data for the whole province has been centralised in the office of the latter officer. This system has been found to be satisfactory and has been recommended to other provinces by the Central Advisory Board of Health.

### RECOMMENDATIONS

#### The Areas served by our short-term Programme

218. *The creation of four registration offices in each primary unit.*—The placing of the registering authority as close as possible to the people is desirable in order to improve vital statistics. We therefore recommend the establishment of four registration offices in each primary unit, one of these being at the headquarters of the unit. The public health nurses and midwives should be made Registrars of Births and Deaths and should be responsible for ensuring that these offices are kept open on the required dates and during the stated hours.

219. All the members of the public health staff employed in the primary unit should systematically check the birth and death registers by house to house enquiry, when they visit villages on their routine duties. In addition, we anticipate that the village committees we have suggested will help to bring on record events which might escape the notice of the *chowkidar* as well as to awaken, in the villagers, a sense of personal responsibility in regard to registration.

#### The Areas outside our Short-term Programme

220 We recommend the employment of non-medical personnel, with some elementary type of training, as Registrars in the areas to which our health programme is not extended. Each man's range of jurisdiction should be limited to such a number of villages as would enable him to visit all of them within a period of about 6 days. During three days in the week he should attend the registration office and the remaining days should be devoted to an inspection of the work of the *chowkidars* in the villages within his area.

#### Certain Other Proposals

221. (a) *House lists in villages and sample surveys.*—We recommend the preparation and maintenance of house lists for individual villages. The list should contain information regarding the name, date of birth and sex of the head of the family and of every normal resident of the house. It should be made obligatory on the householder to give the information required for the filling of the house list, should he be asked by the appropriate authority to do so.

In a subcontinent like India the use of the sampling method is eminently suitable for the collection of demographic information of various types and the provision of an accurate house list for each village will prove invaluable for sample surveys.

222. (b) *The provision of adequate incentive to the people for the registration of births and deaths.*—An effective method of stimulating interest in the people for the registration of vital statistics will be

by creating conditions requiring, in an increasing degree, the production of proof of age, community, parentage etc. If courts, schools etc. could be induced to insist on the production of birth and death certificates the public will begin to feel the necessity for registering births and deaths in their own interest.

223. (c) *Compulsory registration of vital statistics.*—In the areas in which our scheme will be introduced registration of vital statistics should be made compulsory along with the introduction of the scheme, wherever such provision does not already exist. In other areas compulsion should be introduced gradually. The enforcement of the law through the prosecution of offenders is essential if definite improvement is to be secured.

#### **Administrative Organisation**

224. *The central organisation.*—We recommend the appointment of an officer with the title of Registrar General of Vital and Population Statistics. He will be attached to the Central Ministry of Health and will be responsible for the collection, compilation, study and publication of vital statistics from all parts of the country, for the carrying out of the census at periodical intervals and for continuous population studies. He will work independently of the Central Health Department but in close co-operation with it. He should publish an annual report on the population of India incorporating such information as is available regarding existing conditions and possible tendencies for the future.

A "medical section" should be created in the Registrar General's office for the purpose of providing statistical help to the Central Health Department in its day to day administration and in the carrying out of special investigations.

225. *The provincial organisation.*—The provincial statistical organisation should correspond to that proposed for the Centre and the functions of the provincial officer in charge should be similar to those of the Registrar General. The designation of the provincial officer may be the Provincial Registrar of Vital and Population Statistics. He should be attached to the Provincial Ministry of Health for administrative control and should work independently of, but in close co-operation with, the Director of Health Services.

The provision of "a medical section" in the office of the Provincial Registrar for the same functions as those suggested in connection with the Central Health Department is also necessary.

We have also made suitable recommendations for a district vital statistics organisation, which will work under the control of the Provincial Registrar.

226. The employment of statisticians in increasing numbers will become necessary in the vital statistics, health and other departments of Government. Industry is also likely to employ a growing number of persons trained in modern statistical methods. In the circumstances we recommend the development of facilities for statistical training of a high order in the universities and in certain other centres.

#### **PROFESSIONAL EDUCATION**

227. Our main object during the short-term programme should be the provision of adequate numbers of trained staff in all categories, in order to facilitate the development of our health programme with the least possible delay. Before indicating briefly our proposals for the expansion of existing provision for professional education in the

field of health, we may consider certain general questions which are relevant to the subject.

### **The Target in regard to the Production of Doctors**

228. We have placed the target, at the end of the first ten years of the programme, in regard to the production of doctors at an annual output of 4,000 to 4,500 as compared with less than half that number of graduates and licentiates combined now being produced each year. To man the new medical colleges with suitable teaching personnel we anticipate that the All-India Medical Institute, the establishment of which we are recommending, will provide a steady, if limited, stream of teachers of the highest quality. In addition we have suggested that at least 200 carefully selected persons should be sent for overseas training in order to equip themselves for filling teaching posts in the country.

### **The Type of Doctor for the Future**

229. Having given serious consideration to the suggestion that, in the conditions now prevailing in the country, it might be desirable to provide both fully trained doctors and a less elaborate type of medical man, the conclusion which the majority of us arrived at is that, having regard to the limited resources available for the training of doctors, it would be to the greater ultimate benefit of the country if these resources were concentrated on the production of only one and that the highly trained type of physician whom we have termed the "basic" doctor.\*

### **Admission to Medical Colleges**

230. We feel that, as far as possible, the applicants best qualified to make use of the opportunities provided should be admitted into

\*Six of our colleagues (Sir Frederick James, Dr. Vishwa Nath, Messrs. Sapru and Joshi, Pandit Maitra and Dr. Butt) agreed to the advantage of having one single type of medical practitioner, but in view of the overall shortage of doctors, felt that the early realisation of this ideal must be sacrificed to the immediate needs of the country. In their view the imperative and fundamental need in India was the large scale production of trained medical personnel of all kinds and to that end were prepared to use every possible means, including the adoption of a shorter licentiate course to increase, both rapidly and substantially, such personnel.

The majority view, while recognising the need for as rapid an expansion of medical personnel as possible, has taken note of the fact that the "basic" doctor will receive adequate training in the community and preventive aspects of medicine and that he will, therefore, be much better equipped for fulfilling the functions which have been proposed for a medical officer in our programme than a licentiate with his more limited background of general education and of professional training. Moreover, the "basic" doctor, supported by adequate and efficient technicians and other ancillary personnel, is capable of extending his sphere of public utility to an extent which would be beyond the capacity of a less efficiently trained person. It seems therefore likely that the anticipated advantage from a larger out-turn of doctors by the continuance of the licentiate course will be largely counterbalanced by the more efficient and extended service which the "basic" doctor will be able to provide. It is also considered that the production of two types of doctors is to be deprecated on general grounds, because the person with a lower status naturally tends to develop an inferiority complex and a chronic discontent which cannot but be inimical to good work.

A separate note favouring the continuance of licentiate teaching by Drs. Vishwa Nath and A. H. Butt is given in Chapter XVIII of Volume II of the report. On the other hand, three other members (Drs. Amesur, Narayanrao and Wadhvani) consider that admissions to medical schools must be stopped forthwith and that such medical schools as can be up-graded should be converted into colleges even before improvements to existing colleges are carried out. Their note will also be found at the same place in chapter XVIII.

the medical colleges. We realise that there are factors which militate against the application of this principle in its entirety and that communal considerations cannot perhaps be ignored in the present state of the country. We suggest that one-third of the admissions to every medical training institution should be by pure merit and that the remaining seats may be divided among all the communities, provided the best candidates from each community are selected.

231. In view of the importance of increasing to a large extent the number of women doctors in the country we recommend that about a quarter to a third of the admissions in the medical colleges should be reserved for suitable women candidates, if they are available.

#### **Stipends to Medical and Nursing Students**

232. In Russia medical education is free and in the United Kingdom, the Goodenough Committee has recommended that one-third of the admissions to medical schools should be free. In order to prevent economic barriers standing in the way of suitable persons entering the medical profession we would like to see that all those, who are willing to enter the public service after successfully completing their course, should be given an annual stipend of Rs. 1,000, a part of its being recovered from them later in easy instalments. In view, however, of the large financial outlay that this proposal involves we have included, in our estimates, provision only for 50 per cent. of the entrants.

The need for nurses is even greater than that for doctors, there being probably no more than 7,000 registered nurses at present in the country as a whole. On the other hand the implementation of our short-term programme will require approximately 80,000 nurses. We have suggested the provision of a stipend of Rs. 60 per month for pupil nurses, a part of the amount thus advanced being eventually recovered from them in easy instalments.

### **MEDICAL EDUCATION**

#### **Undergraduate Education**

233. Considerable thought has been given by us to the type of training necessary for the evolution of the "basic" doctor and advice was sought from a strong and representative panel of experts in the field of medical education from different parts of the country.\* The main ideas underlying the changes recommended in the undergraduate curriculum include a reorganisation of the teaching both in the pre-clinical and clinical fields; a reduction in the hours of didactic instruction in certain subjects and an emphasis on the inclusion of principles and methods which will enable the student to learn for himself, think, observe and draw conclusions; the establishment, in every medical college, of a Department of Preventive and Social Medicine so as to give the student an insight into social health problems by contacts with home and community life and the inclusion of a year of "internship" after the qualifying examination, of which three months will be devoted to work in a public health unit and the remaining period in a hospital of approved standard. Throughout the whole course, the importance of research should be stressed and whole-time teachers should themselves engage in research and

\*For detailed information regarding our proposals reference should be made to the relevant sections in Chapter XVIII of Volume II of the report

encourage any student showing an aptitude or leaning towards this important aspect of his work to participate in research.

234. Our programme of expansion of educational facilities includes the improvement of existing colleges, the conversion of suitable medical schools into colleges and the establishment of new colleges in different parts of the country.

### **Postgraduate Education**

235. Postgraduate education should be devised to meet two different needs. They are, (a) the training of consultants and specialists and (b) the training of practitioners desirous of practising a speciality without the definite status of a specialist. In the case of (a) such training will naturally involve several years of work in special departments and hospitals and lead to a higher qualification such as the M.D. or M.S. In the case of (b), the training in the speciality concerned may range from 12 to 18 months under suitable guidance. We recommend that courses should be available in (i) Oto-Rhino-Laryngology, (ii) Dermatology, (iii) Radiology, diagnostic and therapeutic, (iv) Ophthalmology, (v) Obstetrics and Gynaecology, (vi) Venereology, (vii) Anaesthesia, (viii) Psychiatry, (ix) Pediatrics, (x) Tuberculosis, (xi) Malariology, (xii) Blood transfusion and resuscitation and (xiii) Orthopaedics.

236. We have suggested the establishment of a special organisation, the Central Committee for Postgraduate Medical Education, to be responsible for laying down standards in respect of postgraduate training in particular subjects and for promoting the development of facilities for such education in different parts of the country on a co-ordinated basis. We have also made suggestions for the apportionment of cost of such institutions between the Central and Provincial Governments.

### **Refresher Courses for General Practitioners**

237. One of the most serious handicaps in raising the general standard of medical practice in India is the absence of any provision for refresher courses. There are several lines along which refresher courses may be arranged.

(i) Whole-time refresher courses which may extend from two weeks to two months. It is desirable to encourage short-term courses of two to four weeks, as many medical men may not find it practicable to be away from their duties for longer periods.

(ii) Part-time courses which may be—

- |                       |  |
|-----------------------|--|
| (a) week-end courses  | } spread over weeks or<br>months organised on a<br>systematic basis. |
| (b) whole-day courses |  |
| (c) half-day courses  |  |

(iii) One educational session once a week or fortnight conducted throughout the year.

(iv) Short-term posts in a recognised hospital for periods ranging from one month to three months.

We recommend that facilities for refresher courses should be developed in all hospitals attached to the secondary health centres, district health centres, medical colleges and the headquarters of each province.

238. We have also made recommendations regarding the provision of training facilities in tuberculosis, mental hygiene and dietetics.

### **Special Provision for Licentiates**

239. There are two types of training that may be given, (1) training which will enable licentiates to obtain a university degree and (2) advanced training in the specialities.

240. (1) *Courses leading to degree qualification.*—The All-India Medical Council has suggested certain changes which some universities have accepted, the result of which will be that the licentiate can within 18 to 24 months obtain the degree of M.B.B.S. Special concessions to those who were serving in the armed forces so that they may, after demobilisation, proceed to a degree have also been recommended. We suggest that it should be the endeavour of every university and every medical college to reserve a sufficient number of places for licentiates so as to enlarge substantially their opportunities to obtain a medical degree.

241. (2) *Advanced training for licentiates.*—There are at present only a few centres where such training can be obtained by licentiates, the School of Tropical Medicine, Calcutta, and the All-India Institute of Hygiene and Public Health being two institutions which afford opportunities for them to acquire their diplomas. It is also understood that the Government of Madras have introduced special courses in Ophthalmology, Obstetrics and Gynaecology, Tuberculosis and Clinical Laboratory Sciences for licentiates. Such diplomas should be made more freely available to them by other authorities in different parts of the country.

## **DENTAL EDUCATION**

242. We suggest that provision should be made for the training of three types of dental personnel, (1) the dental surgeon, (2) the dental hygienist and (3) the dental mechanic. The responsibility for the training of the dental surgeon will have to be shared between medical and dental colleges, while the training of the other two classes can be undertaken entirely by the dental colleges. In view of the difficulty in obtaining well trained dental teachers during our short-term programme, the number of dental colleges that we propose should be opened in the country is limited. We recommend that dental colleges should be established at Calcutta, Bombay, Madras, Lucknow and Patna and that the dental college at Lahore should be expanded. Each dental college for postgraduate students should be associated with a medical college so that the teachers of the latter can assume responsibility for the instruction of dental students in those subjects which form part of the normal studies of the undergraduate in medicine.

### **Postgraduate Dental Education**

243. Appointments as "house surgeons" should be instituted in all dental hospitals run in conjunction with the medical colleges so that dental training on a salaried basis may be available for graduates. In view of the present shortage of teachers, graduates in dentistry should be encouraged to proceed to a higher degree and provision for this should be made in all universities by the establishment of the degree of Master of Dental Surgery. As a temporary measure dental



graduates should be encouraged to proceed overseas to obtain higher qualifications as well as pursue training in special subjects.

### **Dental Legislation**

244. Dentistry as a science can make little progress in the country until it is upheld by suitable legislation directed to compulsory registration and prohibition of practice by unregistered persons. Instead of each province having its own Dental Act, it is suggested that comprehensive all-India dental legislation should be enacted.\*

## **PHARMACEUTICAL EDUCATION**

245. We consider it necessary to provide educational facilities for three classes of personnel, (1) licentiate pharmacists, (2) graduate pharmacists and (3) pharmaceutical technologists. The first class is intended to provide for the large number engaged in dispensing work in chemists' shops, dispensaries and hospitals. The course for the graduate pharmacist will be designed to train the smaller number who will be engaged in manufacturing concerns, analytical laboratories and educational medical institutions. The third type of course is for those desiring to take up the manufacture of pharmaceuticals and drugs on a commercial scale. For them there should be, in addition to the graduate course in pharmacy, an additional course of one year in chemical technology, design, equipment, etc.

As soon as pharmaceutical licentiates become available in sufficient numbers the training of compounders should be dispensed with.

## **EDUCATION OF PUBLIC HEALTH PERSONNEL**

### **Medical Men**

246. We have already referred to the setting up in medical colleges of adequately staffed and equipped Departments of Preventive and Social Medicine and the inclusion of a reasonably high standard of training in this important branch of medicine in the curriculum of the undergraduate medical student. The postgraduate training now provided through the Diploma in Public Health will, we believe, largely be incorporated in the future in the course of training for the undergraduate. Postgraduate training in preventive and social medicine will then have, as its objective, the provision of facilities for advanced training in such branches of the subject as malariology, maternity and child welfare, industrial hygiene, public health administration, epidemiology, public health laboratory practice and statistics. Such specialised training may be of two types. The first will be of a limited character and will have as its purpose the equipment of health workers with a reasonable measure of proficiency in the subject concerned, the course of instruction ranging ordinarily from 3 months to one year. The second will be for those who desire to attain the status of specialists in preventive health work. For them the period of training will be from 3 to 5 years, the candidates being attached to the Preventive and Social Medicine Department of a medical college and being associated more and more with the

\*Mr. N. M. Joshi is, however, of the view that such legislation is premature and that, if it be passed, it should not be made applicable to those areas where the services of a registered dentist are not available within a reasonable distance.

teaching, research and administrative activities of that department, including participation in the field training given to students.

#### **Public Health Engineers and others**

247. Our proposals for postwar health development require a large number of qualified public health engineers for the tackling of the problems of environmental hygiene. A beginning in training can be made at the All-India Institute of Hygiene and Public Health, Calcutta, in collaboration with the Bengal Engineering College and the Calcutta University. At a later stage it is proposed that this subject should occupy a definite place in the course of studies provided at the different engineering colleges so that instruction in public health engineering should form a part of the qualification of all engineers. We have also set out proposals for the training of public health inspectors and public health laboratory workers.

#### **THE TRAINING OF NURSES, MIDWIVES AND DAIS**

248. The conditions under which nurses have been required to carry on their profession in the country are deplorable. These include lack of professional status, insufficient pay for senior positions, gross under-staffing in hospitals and consequent overwork, deplorable living conditions accompanied by overcrowding and lack of recreational and cultural facilities as well as absence of provision for general superannuation or pension schemes.

249. The number of nurses available in the country is probably about 7,000, while our short-term programme will itself require about 80,000 nurses. Without a considerable increase in their number it is impossible to proceed with the development of hospital and other institutional facilities and with the organisation of the public health nursing service for curative and preventive work in the homes of the people. In Chapter I of Volume I of our report we have suggested that, by 1971, the number of trained nurses available in the country should be raised to 740,000. An essential step towards the achievement of this objective is the removal of the existing unsatisfactory conditions of training and service and we have made proposals designed to remove these conditions.

250. The very large majority of nurses who pass out of nursing schools will be absorbed in the public health services. Even so, there would remain a certain number outside this service. We have in mind such nursing services as are maintained by private bodies including Missions. For those who are in public service, provision for old age and insurance against illness, illhealth and disability will form part of the conditions of their service. We would suggest that, for those who are employed by private bodies, provision should be made through a scheme corresponding to the "Contributory Federated Superannuation Scheme for nurses and Hospital Officers" which was introduced in Great Britain in 1928 and has been, it is understood, functioning satisfactorily.

251. As regards training facilities our proposals include the establishment of preliminary training schools which will give elementary instruction to students who wish to become nurses, midwives, public health nurses and hospital social workers as well as the establishment of successive groups of training centres for nurses. In view of the extreme shortage of nursing personnel we have recommended that

the first group of 100 training centres, each taking 50 pupils, should be started two years before the health organisation begins to be established, that another set of 100 centres should be created during the first two years of the scheme and that a third group of the same number of centres should be established before the third year of the second quinquennium.

251. (a) We have suggested that there should be two grades in the nursing profession with corresponding types of training, a junior grade and a senior grade. The entrance qualification for the former should be, we have suggested, a completed course for the middle school standard and for the latter a completed course for the matriculation.

252. We have also recommended the establishment of nursing colleges in order to provide a five-year degree course in nursing as well as advanced courses in hospital nursing administration, in the teaching of nurses and the training of public health supervisors.

### **Male Nurses**

253. Owing to the existing social conditions and customs in certain parts of India, male nurses will have to play an important part in the health programme. Male nurses and male staff nurses should be trained and employed in large numbers in the male wards and male outpatient departments of public hospitals, thus releasing women workers for other work.

### **Public Health Nurses**

254. We have also made specific proposals in regard to the training of public health nurses. They are fully qualified nurses with training in midwifery also. In addition their educational programme should stress, throughout, the preventive point of view. The curriculum should integrate class room instruction in the science and art of nursing and in social studies with well-planned experience in hospitals, community health services and in the home.

### **Midwives**

255. The number of midwives actually available for midwifery duties in the country is probably 5,000. In order to provide one midwife for every 100 births, approximately 20 times that number or 100,000 midwives will be required for British India.

256. Existing training schools for midwives require considerable improvement. The most serious drawbacks are (1) lack of properly trained and well equipped supervisory staff, (2) lack of facilities for antenatal and postnatal work, (3) lack of domiciliary practice and (4) lack of opportunities for witnessing complicated cases of labour. We have laid down certain fundamental requirements which should be met before an institution is recognised as a training centre for midwives and have also made detailed recommendations for their training courses.

### **Dais**

257. The continued employment of these women will, for a period, be inevitable. While recognising that attempts to train the *dai* and make her reasonably satisfactory in the practice of midwifery have in many cases failed, the discrepancy between the existing number of midwives and that required to meet the needs of the country is so great that, as an interim measure, the possibility of elaborating

a system of training whereby the most effective use might be secured out of this type of personnel cannot be ignored. We have described in some detail the experience that one of us (General Hance) has had in developing a midwifery service through trained *dais* in the North-West Frontier Province, where the scheme achieved a reasonable measure of success. We also understand from another member of our Committee (Dr. Butt) that attempts to improve the normal practice of midwifery by *dais* through suitable training have been equally successful in the Punjab. We have, in the circumstances, advocated the training of *dais* as an interim measure until an adequate number of midwives will become available and have made certain suggestions for their training for urban and rural practice.

## MEDICAL RESEARCH

### Existing Medical Research Activities

258. Organised medical research at the present time depends mainly on two organisations (1) the Central and Provincial Government Laboratories and the Medical Research Department and (2) the Indian Research Fund Association. The more important institutes and laboratories existing in the country for the promotion of medical research are shown below:—

(1) The Central Research Institute, Kasauli, (2) The Haffkine Institute, Bombay, (3) The King Institute, Guindy, Madras, (4) The Pasteur Institute of South India, Coonoor, (5) The Pasteur and Medical Research Institute, Shillong, (6) The School of Tropical Medicine, Calcutta, (7) The All-India Institute of Hygiene and Public Health, Calcutta, (8) The Malaria Institute of India, Delhi, and (9) The Nutrition Research Laboratories, Coonoor.

259. Of these, the Central Research Institute, the All-India Institute of Hygiene and Public Health and the Malaria Institute of India are maintained by the Central Government, the Nutrition Research Laboratories by the Indian Research Fund Association and the other institutions, with the exception of the Pasteur Institute of South India, by the Provincial Governments concerned. The last is the property of the Pasteur Institute Association, a body registered under the Societies Registration Act of 1860, and its management is vested in a Central Committee of which the Surgeon General with the Government of Madras is the Chairman and the Director of the Institute is the Secretary. For information regarding the development of these research laboratories and the work that has been accomplished by them, reference should be made to Chapter XIV of Volume I of our report.

### The Medical Research Department

260. The medical research department was established by the Government of India for the provision of a permanent cadre of specially selected and trained officers for the furtherance of research. With the creation of Central and Provincial Government laboratories the officers of this department were appointed as Directors and Assistant Directors of the various Government laboratories. More recently, however, the extended activities of the provincial laboratories have necessitated the employment of workers for special duties and they have been appointed, as required, without drawing upon the medical research department. Officers of the latter department have been

placed on foreign service, from time to time, with other organisations such as the Indian Research Fund Association and the Pasteur Institute Association.

### **The Indian Research Fund Association**

261. The Indian Research Fund Association is a registered association in close touch with the Government of India, from which its funds have been mainly derived. The chief objects of the Association are (1) to initiate, aid, develop and co-ordinate medical scientific research in India, to promote special enquiries and to assist institutions for the study of diseases, their prevention, causation and remedy; (2) to publish papers or periodicals in furtherance of the objects of the Association and (3) to propagate knowledge regarding the causation, mode of spread and prevention of diseases. The entire control and management of the affairs of the Association are vested in a Governing Body, its President being the Hon'ble Member in charge of Health in the Governor General's Executive Council and its Secretary the Public Health Commissioner with the Government of India. The Governing Body appoints a Scientific Advisory Board to advise on technical matters and on allocation of funds, the Chairman of which is the Director General, Indian Medical Service, and the Secretary the Public Health Commissioner. The Association approves an annual programme of research, sanctions grants-in-aid of research and, in certain cases, may constitute special enquiries. An annual conference of medical research workers is normally held, at which the work of the past year is reviewed and proposals for the coming year are put forward.

### **RECOMMENDATIONS**

262. We recommend the constitution of a statutory organisation consisting of:—

(1) a Scientific Board, which will be the executive machinery of the organisation and

(2) an Administrative Body which would form the link between the Board and the Government of India and exercise general supervision over the working of the organisation.

#### **The Scientific Board**

263. The composition of the Board should include medical research workers of standing and experience, representatives of universities and medical colleges, representatives of the principal scientific bodies in India, prominent workers in the field of public health and clinical medicine, non-medical representatives of allied and fundamental sciences and persons with experience of health administration. The work of the Board should be aided by the formation of an adequate number of expert advisory bodies for special subjects.

#### **Administrative Body**

264. The Administrative Body should have the following type of membership:—

(a) the Minister of Health in the Central Government; (b) representatives of the Government Departments of Agriculture, Industry, Labour and Finance; (c) one representative of the Council of State

and (d) two representatives of the Legislative Assembly. The Director General of Health Services with the Government of India should be in attendance at all meetings of this body.

The Board would make recommendations regarding the allocation of funds for the furtherance of research to the Administrative Body, in which would be vested the power of giving sanction to such allocations.

265. The main functions of the central medical research organisation proposed above should be (1) the formulation of policy in regard to the future development of medical research in India, (2) stimulation of research activities in the provinces, universities and medical colleges and (3) co-ordination of such research activities throughout the country.

266. Our recommendations deal also with future developments in respect of Government research institutes and teaching institutions. In addition we have suggested the provision of improved laboratory services in the different provinces through the creation of regional laboratories, to be linked locally with other organisations in connection with the health programme and, for technical direction, with the central laboratory at the headquarters of the province. We have also made suggestions regarding the development of research in special subjects such as malaria and nutrition. Investigation into the social and environmental factors affecting health and disease has also been suggested. For information regarding these matters reference should be made to Chapter XIX of Volume II of our report.

#### **The Recruitment and Training of Medical Research Workers**

267. The number of suitable medical research workers and facilities for training them are inadequate at present in India and, before any expansion of medical research on a reasonable scale can be undertaken, the primary requirement will be a great increase in the number of properly trained workers. Responsibility for recruiting medical research workers and for the creation of training centres for them must be the primary function of the central organisation for medical research referred to above and we have made certain specific recommendations in this behalf also

#### **The Manufacture of Biological Products**

268. One of the activities of Government laboratories is the manufacture of biological products such as vaccines and sera, mainly for the use of Public Health Departments. While recognising that the preparation of these products by commercial firms in India is an industry which is now well established and has been making rapid progress, the majority of us consider that the large scale production of basic prophylactics such as cholera, plague, TAB vaccines, vaccine lymph and anti-rabic vaccine is of paramount importance to the public health authorities in India in protecting the people against epidemics and that their production should therefore remain a Government responsibility.\*

\*Drs. Vishwa Nath and Butt are of the opinion that the time has now arrived when the manufacture of such products should be a responsibility of commercial firms under sufficiently strict Government inspection to ensure public safety. Their views are expressed in a note on medical research, which has been appended to Chapter XIX of Volume II of the report.

## ALL-INDIA MEDICAL INSTITUTE

269. Our recommendations in the section dealing with professional education are intended to promote the production of health personnel under the different categories, in as large numbers and as rapidly as possible. Side by side with these developments, however, we consider it of the first importance that at least a few institutions, which will concentrate on quality, should also be established in suitable centres in different parts of the country. In the first place we recommend the establishment of one such training centre for which we would suggest the designation, All-India Medical Institute. The objects of the Institute should be (1) to bring together in one place educational facilities of the very highest order for the training of all the more important types of health personnel and to emphasise the close interrelation which exists between the different branches of professional education in the field of health; (2) to promote research of the highest type in all the branches of study for which the Institute will be responsible; (3) to co-ordinate training and research; (4) to provide postgraduate training of an advanced character in an atmosphere which will foster the true scientific outlook and a spirit of initiative; (5) to inspire all persons who undergo training, undergraduate or postgraduate, with the high ideals of the profession to which they belong and (6) to promote in them a community outlook and a high degree of culture, in order that they may become active apostles of the progressive spirit in whatever field they may be called upon to serve, whether it be teaching, research, general health work or administration. Though the *alumni* of such an Institute may not be numerous, we feel confident that the influence which they will exert in their respective spheres will be out of all proportion to their numbers.

We recommend that the Central Government should be responsible for its establishment and maintenance.

### The Range of the Institute's Activity

270. We suggest that, in the beginning, the Institute should aim at providing only medical training in all its branches and also the training of nurses. The Institute must therefore have, as an integral part of it, a medical college with its teaching hospitals and laboratories as well as a college to provide the highest type of nursing education. Later on provision should be made for the training of all the higher types of health workers.

### The Selection of Students

271. The students to be admitted to the medical and nursing colleges attached to the Institute should be selected very carefully, merit being the sole criterion for admission. As the needs of the country as a whole are to be served, applicants from all parts of India should be eligible for admission.

### Organisation and Control

272. The organisation and control of the Institute should cover (1) the administrative field and (2) the technical and scientific field.

*The administrative field.*—An institution of the type we envisage should have freedom to develop its own activities independently and without the delaying and hampering effect that strict governmental control may entail. We therefore propose that its administration

should be vested, from the time of its inauguration, in a Governing Body of suitable composition.

*The technical and scientific field.*—Although it may appear somewhat novel in this country, we suggest that the technical work of the Institute should be developed and directed not by an outside body, however eminent its members may be, which will impose its ideas on the Director and Professors of the Institute but the latter themselves acting as a medical faculty. In making this recommendation we are not putting forward a procedure without precedent. We understand that, in the Johns Hopkins Medical School, a similar arrangement has worked successfully for many years and that it has contributed materially to the attainment, by that institution, of the pre-eminent position it holds in the world of medical education. We also understand that this system generally prevails in the United States.

### **Recruitment of the Staff**

273. Our recommendations in connection with the recruitment of the health services, which have been set out earlier, apply generally to the recruitment of the staff of the Institute also. As regards procedure, however, a departure seems desirable from our suggestion that recruitment to the different health services should be made through the various Public Service Commissions. We feel that the adoption of the procedure, which has been practised in the Johns Hopkins University and which we understand is generally followed in other universities in the United States, may with advantage be tried here. In the Johns Hopkins Medical School recommendations for the appointment of professors are made by the medical faculty of that institution, which consists of its own professors. While the authority for making the appointment is vested in the university, it is understood that the recommendation of the medical faculty is invariably accepted. We desire to see this principle adopted for the recruitment of the staff of the Institute, the Governing Body being the appointing authority and the Medical Faculty the recommending body.

### **Finance**

274. We consider that the Central Government should fulfil adequately the responsibility of financing the Institute on a sufficiently generous scale to promote its development into, and maintenance as, an all-India training centre on the lines indicated by us. An appeal should, however, be made to the public for contributions. The Institute is of such paramount importance for the full development of the proposed national health programme that its financial stability should be ensured by the Government of India endowing it with an amount sufficient to secure, through the accruing interest, at least half the estimated annual expenditure of the institution in its fully developed form and by a statutory provision for any balance that private benefactions may fail to provide.\*

### **HEALTH ORGANISATION FOR DELHI PROVINCE**

275. The Central Government should attempt to demonstrate in Delhi Province the effects of implementing not only our proposals

\*Mr. P. N. Saprú and Dr. Hameed do not agree with the rest of the Committee on a few points. Their note is appended to chapter XX of volume II of the report.



but also those put forward by other committees, which have made recommendations for postwar development in different fields of community life. The purpose in view is to demonstrate to the country as a whole what can be achieved, through co-ordinated effort, to improve the health and general prosperity of the community.

### Our Proposals

276. While our proposals for the health organisation in Delhi Province follow the main outlines of the general plan suggested for the country as a whole, there are modifications in certain directions. These are designed to secure a higher level of efficiency in the proposed health service, in view of Delhi being a demonstration centre for the country as a whole. For instance, a rural primary unit in this province will have only a population of 20,000 as against double that number which has been suggested for the rest of the country. The proposed provision for medical relief will be higher in Delhi Province than that suggested by us in other provinces. The dispensary at the headquarters of the primary unit will have five emergency beds as against two elsewhere, while the 30-bed hospital will serve in Delhi a population of 60,000 as against 160,000 in the rest of the country. In view of the limited number of women doctors available in India, our proposals for the appointment of a woman doctor to each primary unit may not be possible of being carried out in the country as a whole in the early stages of the programme. It should, however, be possible for Delhi Province to secure women doctors for the relatively smaller number of such units which will be developed here. In proportion to the population Delhi will have double the number of midwives and trained *dais* in each primary unit as compared with the rest of the country. Thus health work among women and children should be capable of development here on a more effective basis than in the other provinces.

### DRUGS AND MEDICAL REQUISITES

#### Supplies

277. Second in importance only to the provision of trained health personnel must come the supply of the therapeutic substances and medical appliances without which doctors and public health workers generally may be reduced to a state of virtual impotency in the practical exercise of their profession. We have had evidence to show how grave has been the lack in this country of these essentials. Even when they are available, the cost in respect of some is so high as to prohibit or at least gravely restrict their use. Quinine may be cited as an example. We are told that, in the year 1935-36, the actual cost of producing quinine in Bengal from home grown bark was about Rs. 6/8/- a pound, while the Government selling price of this article was Rs. 18 and the market rate Rs. 22 a pound. This market rate was largely decided by an international organisation, Kina Bureau, which controlled about 95 per cent. of world's supply of quinine. Nor can the indigenous profiteer be absolved from the charge of criminal exploitation. We feel that such a state of affairs should not be permitted to continue and that it calls for immediate attention and remedy.

278. We recommend that a small committee, mainly but not entirely technical in composition, should be appointed to examine the question of the requirements of the country in respect of drugs and

other medical requisites. The following are some of the more important matters which it should investigate:—

(a) What are the drugs and other medical requisites essential for general use in the country?

(b) What practical steps should be taken to ensure their manufacture in the country in sufficient quantities and their sale at a price which will make them available to all who need them?

(c) What are the circumstances which would justify the conclusion that the manufacture of any of these in the country is inadvisable?

(d) What should be the respective fields of Government and of private enterprise in the manufacture of these requirements?

(e) What aid and assistance should be given to private agencies in such cases and under what conditions?

(f) What machinery should be established to develop research regarding drugs and other medical requisites and their production in India and to ensure the continuity and co-ordination of such research?

(g) What machinery should be set up to ensure a steady flow of trained technical personnel?

279. We believe that it should be possible adequately to provide for these essential needs through a combination of private enterprise suitably assisted, where necessary, and production by the State where this is found to be in the public interest. The final responsibility should rest with the Government for seeing that the essential needs of the country in respect of all important medical requisites are met and this responsibility should be interpreted as covering the necessity for ensuring that these requirements are met satisfactorily in regard to quantity, quality and price.

### Control

280. The Drugs Act of 1940, which was passed by the Central Legislature, now provides for the regulation of the import into and the manufacture, distribution and sale in British India of drugs. We understand that certain statutory rules under the Act will be brought into force at an early date by the Government of India. The provisions of this Act and the rules made under it should be brought into operation throughout the country and rigidly enforced with the least practicable delay.

## INDIGENOUS SYSTEMS OF MEDICINE

281. We are unfortunately not in a position to assess the real value of these systems of medical treatment as practised today as we have been unable, with the time and opportunities at our disposal, to conduct such an investigation into this problem as would justify clear-cut recommendations. We do, however, say quite definitely that there are certain aspects of health protection which, in our opinion, can be secured wholly or at any rate largely, only through the scientific system of medicine. Thus public health or preventive medicine, which must play an essential part in the future of medical organisation, is not within the purview of the indigenous systems of medical treatment as they obtain at present. The indigenous systems of medical treatment do not also at present deal with such vital

aspects of medicine as obstetrics, gynaecology, advanced surgery and some of the specialities. Further, no system of medical treatment, which is static in conception and practice and does not keep pace with the discoveries and researches of scientific workers the world over, can hope to give the best available ministrations to those who seek its aid.

282. We feel that, we need no justification in confining our proposals to the country-wide extension of a system of medicine which, in our view, must be regarded neither as Eastern nor Western but as a corpus of scientific knowledge and practice belonging to the whole world and to which every country has made its contribution.

283. We have been informed that, in China and Japan, a moratorium extending to a definite period of years was declared after which the practice of the indigenous systems in those countries would not be recognised. We were further told by Dr. Ognev, the Soviet Representative, that indigenous systems of medical treatment were nowhere recognised in the Soviet Union.

284. We consider that it should be left to the Provincial Governments to decide what part, if any, should be played by the indigenous systems in the organisation of Public Health and Medical Relief. It is for them to consider, after such investigation as may be found necessary, under what conditions the practice of these systems should be permitted and whether it is necessary, either during some interim period or as a permanent measure, to utilise them in their schemes of medical relief.

What we have said in regard to the indigenous systems applies generally to Homeopathy also.\*

## **REGULATION OF THE MEDICAL, DENTAL, NURSING AND PHARMACEUTICAL PROFESSIONS**

### **Regulation of the Medical Profession**

285. Practitioners of the scientific system of medicine are, the world over, subject to more or less rigid regulation, the degree of such regulation and the authority from which it is derived varying with different countries. In the United Kingdom this function is vested in the General Medical Council of Medical Education and Registration of the United Kingdom, which was established by the Medical Act of 1858 and which has been vested with the duty of securing the maintenance of the requisite standards of proficiency from candidates at the qualifying examinations for entry into the Medical Register. In India the Indian Medical Council, which was established by the Medical Council Act of 1933, has not been authorised to maintain an all-India Medical Register. The basic qualifications for medical registration are those of medical licentiates, a body of practitioners who are the concern of the Provincial Medical Councils. The maintenance of Medical Registers and the supervision of the basic qualifications required for entry into them are, at present, responsibilities entrusted to Provincial Medical Councils and Faculties. The supervision of the Indian Medical Council is, as yet, restricted to certain medical qualifications which are granted by

\*Drs. Butt, Vishwa Nath and Narayanrao do not accept this view. They desire to see that the services of persons trained in the indigenous systems of medicine are freely utilised for developing medical relief and public health work in the country.

Indian universities and which are incorporated in the First Schedule of the Indian Medical Council Act.

286. We consider this position unsatisfactory. We are recommending that, for the future, there should be only one basic medical qualification for entry into the profession throughout India and that the portal of entry should be a university degree. The production of the licentiate type of doctor will cease after some time if these recommendations of ours are accepted. In the circumstances we recommend that the Medical Council of India should be empowered to maintain an All-India Register when the training of licentiates ceases throughout the country.\*

287. The need for restricting the right to prescribe drugs in the British Pharmacopoea and to practise scientific medicine by unqualified and unregistered personnel was emphasised in our discussions. In this connection we considered the desirability of enacting legislation providing (1) that no medical practitioner should be entitled to affix the designation "doctor" before his name unless he is a registered medical practitioner in modern scientific medicine, (2) that no person should be entitled to prescribe drugs in the British Pharmacopoea, especially injections and poisonous preparations, unless he is a registered practitioner and (3) that those who practise Unani or Ayurvedic systems of medicine should style themselves as "Hakims" or "Vaid" as the case may be.

288. We consider that the public is entitled to know the exact credentials of persons on whom they call for advice and treatment and to protection against fraudulent imposition. We suggest that legislation should be made so as to provide that no person shall be entitled to use the style or appellation of "doctor" other than those who (a) hold the Doctor's degree of a Faculty of a University recognised by the State or (b) are practitioners qualified to practise modern scientific medicine.

289. Rule 65 (9) of the Drugs Rules, 1945, under the Drugs Act, 1940, provides that a number of poisons, which are included in Schedule H of these Rules, shall not be sold in retail except on and in accordance with a prescription of a registered medical practitioner. But Schedule H does not contain all the poisons enumerated in Schedule E of the same rules. We consider that, if Schedule E can also be included within the operation of Rule 65 (9), our colleague's recommendation would be met adequately and that any further restrictive legislation is of doubtful advisability and practicability.

290. The terms "Hakim" and "Vaid" are honourable titles of considerable antiquity and it is by no means clear to us why persons entitled to use these honourable appellations should desire to assume any other. We do not feel competent to make any recommendations regarding the organisation and regulation of indigenous systems of medicine. We therefore confine ourselves to the recommendation that Provincial Governments, if they desire to recognise these systems, might with profit follow the example of the Government of Bombay and enact legislation by which all persons practising any form of the healing art are compelled to secure registration in a

\*Drs. Vishwa Nath and Butt are not in agreement with this recommendation and their note will be found appended to Chapter XXIV of Volume II of the report. They suggest the maintenance of the existing position in respect of all these Councils.

schedule or schedules appropriate to the system in vogue and their qualifications in such system.

### **The Dental Profession**

291. The profession of dentistry is, as yet, totally unorganised in India and no legal provision exists for its regulation. We recommend that legislation should be undertaken in order to create Central and Provincial Dental Councils. The latter should be charged with the duty of recognising training institutions and of creating and maintaining Dental Registers as well as with the disciplinary regulation of the profession, subject to appeal. The Central Dental Council should be concerned with the direction and co-ordination of the activities of the Provincial Councils, the definition and maintenance of minimum educational standards, which implies the right of inspection and recognition of training institutions, the maintenance of an All-India Dental Register, the disposal of appeals against disciplinary decisions by the Provincial Councils subject, as may be necessary, to the directions of the Federal Court and the regulation of reciprocity within and without India.

### **Regulation of the Nursing Profession, including those of Midwives and Health Visitors**

292. At present the regulation of the nursing profession, which includes those of midwives and health visitors, is vested in Provincial Nursing Councils which maintain registers of persons who have completed approved courses of training in institutions recognised by them for the purpose and have passed the prescribed examinations. Persons so registered are entitled to practise the profession in their own province. Arrangements for reciprocity with other provinces exist to a degree which varies with the Nursing Council concerned.

293. We recommend the creation of an All-India Nursing Council to co-ordinate the activities of the Provincial Councils, to lay down minimum educational standards and to safeguard their maintenance. Questions of reciprocity within and outside India should be the concern of this Central Nursing Council. We recommend the maintenance of an All-India Register by this Council, with separate schedules for the entry of approved qualifications in general nursing, higher nursing, public health nursing, midwifery and health visiting.\*

294. The power to take disciplinary action should continue, in the first instance, to be vested, as at present, in the Provincial Councils, but there should be a right of appeal to the All-India Nursing Council over their decisions, with additional provision for further appeal to the Federal Court in circumstances similar to those in which in the United Kingdom, an appeal lies to the High Court against the decision of the General Nursing Council.

### **Regulation of the Pharmaceutical Profession**

295. For the regulation of the pharmaceutical profession we recommend the creation, as in the case of the nursing and other professions referred to above, of Central and Provincial Pharmaceutical Councils with functions which are similar to those indicated in respect of the corresponding Councils for those professions.

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\*Our suggestions for the composition of the Central Nursing Council are given in Appendix 50 of Volume III of the report.

## **EMPLOYMENT OF DEMOBILISED PERSONNEL OF THE MILITARY HEALTH SERVICES**

296. During the present war the Indian Army has expanded more than ten times its peace strength and, as a corollary, the military health and nursing services have undergone a considerable expansion. In addition to this phenomenal enlargement, the military medical services have undergone a radical reorganization and development dictated by the intensive application of modern science to military medical problems, which have greatly increased the professional and technical value of the personnel concerned. As a result, there exists in the medical and ancillary services of the Indian Army a great reservoir of personnel, whose training and experience render them particularly suited to employment in the civil health services. This personnel comprises Medical Officers (male and female), Dental Officers, Nurses and Technicians. We have given in Chapter XXV of Volume II a short description of each category and the civil employment for which individuals in that category would appear to be suitable.\*

297. We would emphasise the supreme importance of this reservoir of trained talent being made available to the fullest possible extent to the health services of the country. If this opportunity of providing trained personnel for the carrying out of our proposals is allowed to pass without full advantage being taken of it, it may materially delay the initiation of the nation-wide health programme for the country which we contemplate. We therefore consider it essential that the services of all such personnel should be utilised, except in cases of proved unsuitability.†

## **THE ESTABLISHMENT OF A COMMITTEE OF STANDARDS FOR MEDICAL INSTITUTIONS AND EQUIPMENT**

298. In view of the heavy constructional programme which will have to be formulated to supply the new accommodation required under our proposals, to carry out the structural alterations necessary in respect of existing buildings and to provide the vast number of fittings of all kinds required by laboratories, health centres, hospitals etc., it seems desirable that some system of standardization should be evolved which will introduce order into what may otherwise well tend to become chaos. With the achievement of order, there will be obtained the further advantage of reduced cost that automatically accompanies effective standardization. We urge the setting up of a Committee of standards for Medical Institutions and Equipment and suggest that it should be closely linked with the appropriate section in the Central Ministry of Health. Its composition should include:—

- (1) architects with experience of designing and construction of medical institutions under tropical conditions;
- (2) engineers with similar experience;

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\*We have also given in a tabular statement (Appendix 53 of Volume III of our report) for which we are indebted to the Resettlement Section of the Office of the Director General, Indian Medical Service, detailed information regarding demobilised personnel.

†Drs. Vishwa Nath and Buft, Sir Frederick James and Lieut.-General J. B. Hance desire to lay further emphasis on the remobilisation, for civil purposes, of demobilised medical and ancillary personnel and their separate note will be found at the end of Chapter XXV of Volume II of the report.

(3) medical practitioners, not merely as doctors, but as having an interest in, and experience of, design, construction and administration of medical institutions;

(4) laboratory scientists with an interest in the elaboration of laboratory fittings on a transferable unit system and

(5) members of the nursing profession with a special knowledge of the problems of internal hospital design.

299. We recommend that the Committee should, among other things, give serious consideration to the feasibility of adapting some of the many existing buildings of a temporary nature, which have been set up for war purposes by the military and civil departments of the Central and Provincial Governments, to purposes in connection with our health development programme.

### **RE-EMPLOYMENT OF PERSONS WHO HAVE REACHED THE AGE OF SUPERANNUATION**

300. Among the major difficulties which have to be overcome in the successful implementation of our recommendations probably the greatest is the general inadequacy of existing health personnel and, in some cases, the entire absence of certain classes of professional and technical workers. The need for trained personnel is so clamant as to make the rigid maintenance of the normal rule that Government servants should be superannuated at the age of 55 inconsistent with the requirements of the situation, at any rate throughout the short-term period and probably in the earlier years of the succeeding period. Subject to physical and mental fitness persons who have reached the age of superannuation should be permitted to continue to work on a year to year basis, on the condition that they are found fit by the medical board on each occasion. In order to ensure that the continuation in service of such persons does not stand in the way of normal promotions in the health services, they should be made to retire before they are re-employed.

These recommendations of ours should apply to all members of the health services.

### **THE POPULATION PROBLEM**

301. The steady growth of population, which has taken place during the past few decades, has had its repercussion on all such matters as the housing, clothing and feeding of the additional numbers brought into existence from year to year, their education and the provision of adequate measures for the protection of their health. No programme of social reconstruction can, therefore, afford to ignore the implications of the population problem.

302. The three main factors which influence the growth of population are (1) migration, (2) mortality and (3) fertility.

#### **Migration**

303. Owing to the restrictions which the Governments of other countries have placed on the entry of Indians into their territories, the effect of migration on India's population has been negligible for some time past and is likely to be so, at least for some time longer.

#### **Mortality**

304. During the past two decades there has been a steady fall in the mortality rate of the country. A further fall is bound to

occur if the large scale programmes for improving the health of the community advocated by the different postwar planning committees are effectively put into operation. There is every reason to believe that there will be a saving of at least three million lives every year in British India, which will bring its rate of mortality down to the level of what has already been accomplished in a number of other countries. In the decennium between 1931 and 1941 the average yearly addition to the population of India as a whole was 5 millions. An annual saving of 3 millions in British India as the result of improved health conditions will raise India's rate of growth to 8 millions a year, without taking into consideration any fall in mortality that may be brought about in the Indian States through similar health measures. Under such conditions the very large increase of 83 millions, which took place in the 20-year period between 1921 and 1941, is likely to be reached within half that time. A purposeful control of mortality, without a corresponding fall in the fertility rate of the community, can thus have far-reaching consequences.

### Fertility

305. All available information seems to suggest that the fall in the fertility rate in India during the past 60 years has been negligible compared with the fall in mortality. In this connection certain estimates of the rates of fertility and mortality for the country are quoted from an interesting study of India's population problem by Kingsley Davis, under the title of "Demographic Fact and Policy in India," published in the Milbank Memorial Quarterly (July 1944).

Year	Estimated	
	Fertility rate	Death rate
1881—1891 . . . . .	49	41
1891—1901 . . . . .	46	44
1901—1911 . . . . .	49	43
1911—1921 . . . . .	48	47
1921—1931 . . . . .	46	36
1931—1941 . . . . .	45	31

306. It seems fairly clear that, at least in the immediate future, there is little reason to believe that there would be a marked fall in the fertility rate of the country.

### Our Recommendations

307. In the absence of certain natural checks such as famine and disease whose operation will, speaking generally, become more and more limited as our various programmes of social security and improvement in living conditions develop, the growth of population in India will become an increasingly serious problem. Growth of population may be prevented from becoming a menace to the standard of life of the community (a) by migration, (b) by increasing the production of natural resources and (c) by a reduction in the rate of



additions to the population. We have already pointed out that the prospects of emigration helping to lessen the pressure of population on the means of subsistence in the country appear to be remote.

### Increased Production

308. The advance of science, careful planning and concentrated effort on the part of the community to develop the country's resources may make possible the support of a largely increased population on even a better standard of living than that which exists at present. Such measures, however, can constitute only a temporary expedient, because a limit to economic productivity will be reached, sooner or later, and uncontrolled growth of population must, as far as we can see, outstrip the productive capacity of the country.

### Reduction in the rate of Additions to Population

309. Our social instincts militate against a reduction in the rate of growth of population being brought about by permitting the death rate in the community to rise. We have therefore to turn to three other means for decreasing the rate of growth, namely, (1) a raising of the age of marriage for girls, (2) an improvement in the standard of life and (3) intentional limitation of families.

310. *Raising of the age of marriage for girls.*—Carefully collected statistics from several countries support the view that the fertility of women is at its highest during the age period 15 to 19. The raising of the age of marriage for girls by a few years from the present minimum of 14 would probably effect a reduction in the birth rate. There are also strong physiological reasons for raising the minimum age for the marriage of girls to 16, 17 or even 18. We refrain, however, from making a specific recommendation, partly because we are not unanimous on the point and partly because the question is so intimately bound up with social custom and tradition, that the Governments concerned should consider the state of public opinion before taking any decision.

311. *Improvement in the standard of living.*—An improvement in the standard of living generally tends to promote a lowering of the birth rate by helping to create an incentive in individuals to limit the size of their families in the interests of maintaining for themselves and their children a reasonable level of comfort and of enabling the latter, through proper education and through the opportunities for earning their living which such education offers, to keep up the standard of life to which they had been accustomed. Such rise must however be a slow process and, while this development goes on, it seems likely that the active measures introduced by the proposed health services will result in an appreciable reduction of the death rate and thus produce a temporary acceleration of the rate of growth of population.

312. *Intentional limitation of families.*—If we believe that limitation of families is advisable, we should first ask ourselves the question whether it is possible that this could be secured through self-control. Our answer must be, we fear, not to any material extent.

While a limited number of individuals may be under-sexed or may, by nature, be so constituted that they can sublimate most of their sexual urge into intellectual, artistic or other creative channels, the large majority of mankind although able to convert a part of their sexual impulse into activities useful to the community, may still have to find satisfaction in the sexual act itself. In the circumstances we seem to be left with birth control through positive means as the only method which is likely to be effective.

### **The Extent to which the State should help to promote the Birth Control Movement**

313. All of us are agreed that, when childbearing is likely to result in injury to mother or infant, there is every justification for the practice of contraception. In such cases it should be the responsibility of Governments to provide instruction regarding contraception in maternity and child-welfare centres, dispensaries, hospitals and any other public institutions which administer medical aid to women. We also consider that the supply of contraceptive requisites should be made, free of cost, by the State to necessitous women when the practice is advocated for reasons of health. There is also unanimity among us in respect of State action in two other directions, namely. (1) control over the manufacture and sale of contraceptives as in the case of food and drugs and (2) assistance from public funds towards research for the production of a safe and effective contraceptive.

314. Some of us are of the opinion that, on economic grounds also, contraception is justified in the interests of the individual and of the community and that the State should provide facilities for imparting knowledge regarding birth control when desired for such reasons. The others, while they fully appreciate the importance of relating population to the economic resources of the country, feel that the active promotion by the State of contraceptive practices for economic reasons will be justified, in view of objections to it on religious grounds in certain quarters, only if there is substantial support from public opinion.

### **The Extent to which the proposed Measures are likely to Restrict the Growth of Population**

315. For various reasons, which include the inadequacy of medical women and of health visitors to impart birth control knowledge to the women of the country, the enormous cost of making a safe and effective contraceptive available to the people, the inability of the majority of women to learn and practice contraception satisfactorily and the disfavour with which certain communities look on birth control for religious reasons, we believe that a rapid extension of the practice of contraception among the people is unlikely in the immediate future. It also appears to us that there is little immediate prospect of raising the age of marriage for girls by legal enforcement. On the other hand, as has already been pointed out, the immediate prospect is that, with the introduction of the proposed health services and of the measures designed to advance the welfare of the community, the rate of growth of population may show an acceleration as compared with the past. While recognising fully the implications of this increase in population, we feel that the only practical steps that can be taken are (1) a relentless pursuit of the

measures that are now being proposed for the reconstruction of national life in order to raise the standard of living and (2) the spreading of the knowledge of birth control as far as the limitations imposed by the peculiar circumstances of the country will permit.

### **Genetics and Population Policy**

316. The application of knowledge regarding heredity for the development of a healthy and vigorous stock of different species of animals and plants has been made by man with remarkable success in respect of many forms of life. As regards man, however, the extent of our knowledge regarding the hereditary transmission of disease and defect is at present very limited and, with the existing knowledge, it would be difficult to formulate and execute an effective population policy directed to promote the creation of a healthy and well-endowed community. We therefore consider it desirable that, as a part of the study of the population problem in India, the part which heredity and environment play in the transmission of valuable human traits and of defects should be investigated.

### **Study of the Population Problem**

317. It is highly desirable that the population problem should be the subject of continuous study. Apart from the probable trend of population growth, such matters as differential fertility and mortality rates and surveys of morbidity among the various sections of the community are of interest and importance from the point of view of sound administration. The problems of heredity and environment in relation to population policy should also receive consideration. We desire to see such studies organised and conducted on as broad a basis of collaboration as possible and suggest that the Registrar General and the Provincial Registrars, with their respective staffs of trained statisticians, the Health Departments, Central and Provincial, and the Departments of Economics, Sociology, Statistics and Genetics in the Universities, wherever they exist, should participate in such studies.

### **ALCOHOL IN RELATION TO HEALTH**

318. Drinking has, as pointed out by Professor Sigerist in his book "Civilisation and Disease", two main causes. "One is social and economic. Misery, poor living conditions, lack of education and of recreational facilities drive a man into drinking. In Russia in 1913, the annual consumption of vodka amounted to 8.1 litres or more than 2 gallons per person, and the average worker spent over a quarter of his wages on liquor. When conditions of the working population changed after the Revolution the *per capita* consumption of liquor dropped steadily. It was 4.5 litres in 1931, 3.7 in 1935..... Another cause of harmful drinking is to be sought in folk customs and group habits. Since alcohol removes inhibitions and makes people talk more freely, it became the custom to drink alcoholic liquors whenever people gathered for social intercourse. This *alcoolisme mondain*, as the French call it, affects the most highly educated classes. It is not so spectacular, but has nevertheless very deleterious results." A campaign for reducing alcoholism in the community must therefore take into account both these factors. A rise in the standard of living accompanied by the provision of educational and recreational facilities on as wide a scale as possible seems to be essential to ensure the success of the campaign. The

harmful effects of convivial drinking can be brought home to the people and their co-operation secured for its effective control only through education.

#### **Education regarding the Fundamental Facts in relation to Alcohol**

319. In the United States, all but two States (Arizona and Wyoming) have laws requiring that all schools supported partly or wholly from public funds should include, in their curricula for children, courses of instruction dealing with the effects of alcohol and other narcotics on the human system. We desire to see such provision made in this country also. Proper text-books on the subject should be prepared by some central agency and they should be translated into all the languages of individual provinces by the respective Provincial Governments. In doing so it should be possible to include material, diagrammatic and narrative, which will give a local colour to the different subjects that are discussed.

#### **Certain Other Suggestions for Combating Alcoholism and for Restricting Alcohol Consumption to the Minimum**

320. We recommend the strict control of existing liquor shops and the severe restriction or even prohibition of opening new shops, particularly in the areas occupied by the poorer sections of the community, including industrial workers. There should be a reduction in the hours of sale of alcohol. The alcoholic content of the beverage sold in such places for public consumption should be within certain limits to be prescribed by the Provincial Government. The aim should be to make the places, where alcoholic beverages are permitted to be sold, decent establishments where a high standard of cleanliness is maintained and suitable alternative refreshments are provided, so that a man can take his family and order food along with drinks. The experience in the West is that, under such conditions, the excessive consumption of alcohol is generally checked. There should also be provision for the supply of non-alcoholic beverages. Milk bars, tea and coffee shops, if run on cheap lines, can help to divert the craving for intoxicating drinks into less harmful channels. The desire for alcohol at the close of the day is perhaps partly stimulated by the lack of opportunities for other forms of useful activity, including recreation and social intercourse.

321. Provincial Governments obtain today a substantial part of their revenues from alcohol. "Little economic merit can be claimed for a system of taxation which raises any considerable part of the public revenue from the sale of alcohol, unless, as a part of the plan of government, this tax money is used to reduce the extent of facilities for the sale of alcoholic beverages; to promote observance of restrictive laws; to meet the cost of prevention, care and treatment of alcoholism among the considerable number of persons whose health will be injured and whose earning capacity will be reduced by the use of alcohol". It seems important to us that a substantial part of the money so derived should be devoted by Governments in this country to measures designed to prevent the spread of alcoholism and to rehabilitate those whose health and working capacity have been injured by the excessive use of alcohol.

#### **Treatment and Rehabilitation of Alcoholics**

322. The treatment of acute and chronic alcoholism is essentially a medical problem and adequate provision should be made for it as

a part of the general health programme. The rehabilitation of the chronic alcoholic is, however, a much wider problem. Here, apart from any medical measures that may be adopted, there is the question of re-educating him to a saner outlook on life and his responsibility towards those who are dependent on him. The rescuing of the growing children in the home of such an individual from the degrading effects of brutish behaviour resulting from drunkenness is an equally important matter. The establishment of houses of detention for those alcoholics who require segregation and treatment, medical and social, should receive serious consideration. Legal sanction for such detention will, no doubt, be required and the question of acquiring the necessary powers should also be considered. In this sphere of activity voluntary effort can render valuable help. The rescuing of the individual back to normality can be helped enormously by properly directed efforts in which social workers and religious leaders should take an active part.

323. The consumption of alcohol, during working hours, by persons engaged in certain occupations is dangerous to themselves and to others. For instance, pilots in charge of aeroplanes and motor-drivers should be forbidden alcohol during working hours. It should be an offence punishable under the law for such persons to be found in a drunken state when engaged in their respective occupations. We have given these only as typical instances and there are many others in which the use of alcohol should be equally forbidden in the interests of the community. There is abundant evidence to show that the efficiency and output of the industrial worker are lowered by alcohol and that the accident rate is raised. The enforcement of total abstinence during working hours appears therefore to be of advantage from the point of industry and of workers alike.

### THE INSTITUTION OF A MEDICAL LIBRARY SERVICE

324. One of the prime needs of an intellectual community is an effective library service and this is more especially the case where a highly technical subject such as medicine is concerned. India is at a great distance from other centres of scientific thought and she must inevitably draw her knowledge of advances and discoveries from books and journals published in other countries. She must be largely self-contained and the need for a full and well-selected Central Library is even greater than that of Europe and America, where facilities for the dissemination of knowledge are more highly developed.

325. India has not the funds to enable her at present to institute a library comparable with the more important libraries of the world, such as Washington with its 420,000 volumes, Leningrad with 600,000, Paris with 500,000 or even with that of the Royal Society of Medicine in London with 160,000 volumes. It seems to us, however, to be not unreasonable that we should recommend the establishment in India of a Central Library, providing, in the first instance, for the housing of 60,000 to 100,000 volumes.

326. In order to put the proposed library service on a sure foundation, an exploratory survey of the facilities existing in the United Kingdom, the United States and elsewhere should be undertaken by one or two officers (of whom at least one should be an Indian) deputed for the purpose.

327. There should be, in London, a correspondent to the library who will watch its interests in the West and act as the channel both of information and of supply in matters concerned with the library service.

328. The Central Library we envisage is one chiefly devoted to research and should be established in association with the All-India Medical Institute. When similar medical institutes are established elsewhere they will have to be provided with their own libraries. A case can be made out for an entirely separate library in the directorate of the future civil health service. We prefer, however, to leave that question, together with the proposals for the establishment of regional libraries, to the consideration of the Governments concerned after the survey, which we have suggested has been completed, when fuller and more exact information will be available.

### LEGISLATION

329. Our proposals for legislation fall mainly under four heads:—

(1) those which are intended to assist in the formulation and execution of a national health policy based on the largest possible agreement between the Central and Provincial Governments and to promote the co-ordination of central and provincial health activities;

(2) those which are designed to improve health administration in the provinces, particularly the standard of such administration in local areas;

(3) those which are required for conferring special powers on health authorities to enable them to carry out their duties more effectively than they are able to do at present and

(4) those which are intended to give statutory sanction to certain proposals of ours, *e.g.* the establishment of the All-India Medical Institute, the Central Committee for Postgraduate Medical Education and Central and Provincial Water and Drainage Boards.

#### **Consolidated Public Health Acts, Central and Provincial**

330. In addition we recommend the enactment of consolidated public health Acts by the Central and Provincial Legislatures. Such Acts can serve at least three purposes, namely, (1) to bring together existing legal provisions relating to health, which are scattered over various enactments, (2) to modify those sections of the law which require change in the interests of promoting efficient administration and (3) to incorporate the new provisions which will be necessary for the development of the health programme we have recommended. At the Centre provisions relating to health are found in about 40 different Acts while, in the provinces also, a varying number of legal enactments contain such provisions.

331. Such legislation at the Centre and in the Provinces may take some time to materialise. In the meantime it is recommended that the Central Government should undertake to bring together, in a single publication, all the existing laws relating to health, both Central and Provincial.

### **THE FINANCIAL IMPLICATIONS OF THE PROGRAMME**

332. In drawing up our proposals for the short-term programme we have given careful consideration to the instructions of the Government of India on the financial aspect of planning, which were embodied in the terms of reference defining the scope and nature of enquiry entrusted to us. The Government of India said that it

was desirable "to plan boldly, avoiding on the one hand extravagant programmes which are obviously incapable of fulfilment and on the other halting and inadequate schemes which could have no effect on general health standards and which would bring little return for the expenditure involved". We decided that our guiding principle should be that the short-term plan must produce an appreciable improvement in the health of the people within the period of completion of the plan. This is a matter of even greater importance than questions of cost. We were strengthened in this view by two considerations. One is that planning would defeat its purpose if no satisfactory results could be demonstrated. The consequences of such failure might even be a set-back, for many years to come, in the development of health administration in the country.

333. The other consideration is that, if the rates of expenditure incurred by Provincial Governments on their medical and public health departments were to be taken even as an approximate guide to determine the financial limits of our proposals, any attempt to build a satisfactory scheme of health services for the people would be foredoomed. In 1939-40 the *per capita* expenditure on these two departments together was Re. 0-1-7 in Bihar, Re. 0-1-9 in the United Provinces, Re. 0-2-7 in Bengal. The highest figure for such expenditure was Re. 0-5-9 in the province of Bombay. In order to ascertain what an improved health service is likely to cost it may not be out of place to examine the corresponding expenditure for certain other countries, where the provision for affording health protection to the people exists on a much larger scale than in India. In Great Britain, the *per capita* expenditure on medical and public health activities was, in 1934-35, about Rs. 54-8-11 and in the United States the corresponding figure for 1938 was Rs. 51-6-0. The expenditure incurred by a country on its health services must necessarily depend on its national income and India compares, in this respect, very unfavourably with the two countries mentioned above. Certain estimates of national income for these three countries from sources to which we may reasonably attach value are quoted below:—

Country	Income <i>per capita</i>			Source of information
	Rs.	A.	P.	
British India	62	3	3	The National income of British India 1931-32, by Dr. V. K. R. V. Rao.
Great Britain	1,049	6	5	Journal of the Royal Statistical Society, Vol. 103, 1940, page 517.
United States	1,371	7	3	Monthly Labour Review, Vol. 53, 1941, page 114.

334. The *per capita* income of the United States is about 22 times that of India and that of Great Britain about 17 times. Even after making due allowance for the much higher national incomes in those countries, India should spend annually about Rs. 3-3-0 per head of the population if her expenditure on health services were to bear the same relation to national income as the amount spent in Great Britain in 1934-35 on health measures bore to her own national income. On the basis of a similar comparison with the United States India's *per capita* expenditure on health should be Rs. 2-5-0. From our survey of modern trends in the organisation of health services in Chapter II of Volume II of our report it will be seen that the auth-

ties in those countries are dissatisfied with the provision for the health protection of their people and that expenditure on a generous scale to augment the existing services is under active consideration. In these circumstances, if India desired to develop a modern health organisation, a scale of expenditure much in advance of what the provinces have been incurring, was inevitable. We therefore decided to plan our short-term programme undeterred by the cramping limitations of existing provincial expenditure and with our main consideration directed to the development of a plan which would ensure, through its execution, a demonstrable improvement of the public health.

### The Estimates of Cost

885. We give below, in tabular form, the main items of our estimates of cost separately for the first five years and the second five years of the short-term programme.

*Approximate estimates of cost in respect of the proposals of the Health Survey and Development Committee for British India.*

### NON-RECURRING EXPENDITURE

—	First five years	Second five years	First ten years
	Rs.	Rs.	Rs.
1. Personal health services including the directional organisations associated with the Ministries of Health at the Centre and in the Provinces.	80,88,00,000	118,64,00,000	199,52,00,000
2. Professional education .	22,45,00,000	19,86,00,000	42,31,00,000
3. Expenditure on other items .	50,42,00,000	50,20,00,000	100,72,00,000
	153,75,00,000	188,70,00,000	342,45,00,000
4. Centre . . . . .	9,22,00,000	11,32,00,000	20,54,00,000
5. British India as a whole .	162,97,00,000	200,02,00,000	362,99,00,000

### RECURRING EXPENDITURE

1. Personal health services including the directional organisations associated with the Ministries of Health at the Centre and in the Provinces.	116,10,00,000	250,02,00,000	366,12,00,000
2. Professional education .	32,00,00,000	35,24,00,000	67,24,00,000
3. Expenditure on other items .	4,54,00,000	12,32,00,000	16,86,00,000
4. Leave reserve . . . . .	7,83,00,000	15,08,00,000	22,91,00,000
	160,47,00,000	312,66,00,000	473,13,00,000
5. Centre . . . . .	9,63,00,000	18,76,00,000	28,39,00,000
6. British India as a whole .	170,10,00,000	331,42,00,000	501,52,00,000
Payment towards amortisation of non-recurring expenditure.	25,76,00,000	74,54,00,000	100,30,00,000
Total recurring expenditure .	195,86,00,000	405,96,00,000	601,82,00,000
Average annual expenditure .	39,17,00,000	81,19,00,000	60,18,00,000
Average estimated population of British India.	315 millions	337·5 millions	326·25 millions
	Rs. A. P.	Rs. A. P.	Rs. A. P.
Annual per capita expenditure .	1 4 0	2 7 0	1 14 0



336. After making allowance for the low national income of our country as compared with those of Great Britain and the United States, the rate of expenditure on medical and public services in India should be about Rs. 3-3-0 per head of the population in order to reach the level of similar expenditure in Great Britain in 1934-35, and about Rs. 2-5-0 to reach that of the United States in 1938. Our proposals involve, during the first ten years of their execution, an anticipated expenditure of Rs. 1-14-0 per head of the population. We therefore claim that the programme of health development we have put forward cannot be considered extravagant from the financial point of view. When it is remembered that, in Great Britain and the United States, a further rise in public expenditure on health services has been considered essential in the interests of the people, we hold that there is still greater justification for considering that the demands which our scheme will make on the public purse are in no way unreasonable.

### The Financing of the Health Programme

337. We realise, at the same time, that even the proposed *per capita* annual expenditure of about Rs. 1-4-0 during the first five years of the programme will require that Provincial Governments should make provision, for spending on health measures, amounts many times in excess of what they are budgeting now. The latest available figures for the combined expenditure on provincial medical and public health departments relate to 1944-45 and they are given below.

*Combined expenditure on medical relief and public health activities in the provinces during 1944-45.*

Province	Expenditure <i>per capita</i> in annas	Expenditure on medical relief and public health expressed as a percentage of total provincial expenditure
Madras . . .	6·2	4·7
Bombay . . .	10·9	4·5
Bengal . . .	7·1	5·7
U. P. . . .	3·9	4·9
Punjab . . .	6·1	5·1
Bihar . . .	3·2	7·3
C. P. and Berar . . .	2·8	3·1
Assam . . .	5·4	6·2
N.-W. F. P. . . .	7·7	5·0
Orissa . . .	3·4	5·9
Sind . . .	8·2	2·5

338. While a small number of items of existing expenditure in the provinces on health administration will fall within the cost of the scheme, the vast majority of them will not and, broadly speaking,

the expenditure involved in the execution of our proposals will be in addition to what the Governments, Central and Provincial, are now incurring on their medical and public health departments, which as shown above is generally on a meagre scale.

339. A reference to the last column of the above table will show that the expenditure incurred by Provincial Governments on health measures, curative and preventive, constitute but a very small fraction of their total annual expenditure, the percentage ranging from 2.5 to 7.8. On the other hand, the corresponding percentage in Great Britain during 1934-35 was 20.4 and in the United States 13.8 during 1938. It is obvious that Governments in India have, in the past, devoted an unduly small proportion of their incomes to health administration and there is therefore every justification for demanding that the ratio of expenditure under this head must be raised considerably. Governments should be prepared to increase the money spent on health to at least 15 per cent. of the total expenditure. If this is done a considerable advance will have been made in providing the required funds for the proposed health programme. At least in one province (Madras) the local legislature has laid down (Section 127 of the Public Health Act) that every municipality "shall earmark not less than 30 per cent. of its income from all sources other than Government grants, for expenditure on the advancement of public health in its local area, including expenditure on medical relief, and every district board or *panchayat* shall similarly earmark not less than 12½ per cent. of its income from such sources". We recommend that it should be a statutory obligation on Governments to spend a minimum of 15 per cent. of their revenues on health activities.

340. We consider it highly desirable that a searching enquiry should be instituted into building costs and the data on which Public Works Departments base their estimates. Instances have been brought to our notice in which private agencies have been able to carry out new building work at less than 50 per cent. of the estimates prepared by the Public Works Departments. We do not venture to base any criticism on such information, but there is undoubtedly a widespread and persistent belief that the Public Works Departments are unduly expensive agencies for the construction of public buildings. This calls for careful investigation, as considerations having far-reaching consequences for development in many spheres are involved. In this connection we wish to draw attention to the report of a Mission which was sent to the United States of America by the Ministry of Works in the United Kingdom in 1944. The object of the Mission, which was an expert body, was to study American practice with a view to securing in Great Britain in the postwar period (a) increased speed and output, (b) reduced building costs, (c) improved standard of equipment and finish and (d) improved conditions for operatives.

341. An enquiry into building methods and costs, with special reference to the Central and Provincial Public Works Departments in India would now be helpful, particularly if, with the enquiry, one or two of the representatives of His Majesty's Government's Mission to the United States were associated as well as some non-technical

342. We desire to stress the organic unity of the component parts of the programme we have put forward. Large scale provision for the training of health personnel forms an essential part of the scheme, because the organisation of a trained army of fighters is the first requisite for the successful prosecution of the campaign against disease. Side by side with such training of personnel, we have provided for the establishment of a health organisation which will bring remedial and preventive services within the reach of the people, particularly of that vast section of the community which lies scattered over the rural areas and which has, in the past, been largely neglected from the point of view of health protection on modern lines. We have drawn attention to these aspects of the health programme because we feel that it is highly desirable that the plan should be accepted and executed in its entirety. We would strongly deprecate any attempt, on the plea of lack of funds, to isolate specific parts of the scheme and to give effect to them without taking into consideration the inter-relationships of the component parts of the programme. Our conception of the process of development of the national health services is that it will be a co-operative effort in which the Centre, acting with imagination and sympathy, will assist and guide a co-ordinated advance in the Provinces. We therefore look forward to a pooling of resources and of personnel, as far as circumstances permit, in the joint task that lies before the Governments.

J. W. BHORE, *Chairman.*

F. E. JAMES,

VISHWA NATH,

B. SHIVA RAO,

*Members of the Sub-Committee appointed  
by the Health Survey and Development  
Committee to prepare the summary.*

K. C. K. E. RAJA, *Secretary.*

NEW DELHI.

*The 13th January 1946.*